Prevention of Postpartum Hemorrhage Initiative (POPPHI) Project

Semi-annual Report

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1. Progress

Progress is being defined according to activities completed in the work plan.

1.1 Summary of Activities

Prevention of Postpartum Hemorrhage Initiative (POPPHI) project made significant progress during the final 6 months of year 2 to expand its efforts to decrease postpartum hemorrhage (PPH) through the use of active management of the third stage of labor (AMTSL) and community-based interventions, such as misoprostol. POPPHI increased its global leadership role, as seen by the results of POPPHI's activities through changes in outdated policies on AMTSL practice and the choice of uterotonic drugs used by countries and organizations working in maternal and newborn health (including Nepal, Ghana, Tanzania, Ethiopia, Ecuador, and the Dominican Republic). Partnerships with the World Health Organization (WHO), the United States Agency for International Development (USAID) bilateral programs, Support for Analysis and Research in Africa (SARA)/Africa 2010, and Rational Pharmaceutical Management (RPM) Plus have expanded POPPHI's ability to show impact in its work and are leading to important policy changes for oxytocin and misoprostol as well as the ability of health providers to use AMTSL. The completion of the global survey on AMTSL in Ethiopia and Tanzania countries has already had impact beyond those countries, and the materials developed and online services available through POPPHI have proven useful to many countries, organizations, and colleagues working in this field, as seen by the activity on the Web site and the corresponding user compliments. Highlights of POPPHI activities during this period follow.

- Through multiple efforts, oxytocin is recognized as the drug of choice for AMTSL and is less stigmatized by its cold storage requirements through POPPHI efforts. These efforts include the Practical Guidance on The Use, Management and, Storage of Oxytocics meeting, which united important players in their effort to increase the use of oxytocin; focused messages in conferences and in policy briefs; and targeted information on the POPPHI Web site and list-serv.
- The small grant awardees in the Dominican Republic have galvanized suppliers of oxytocin to donate supplies to hospitals, which is an excellent example of improving health care through public–private partnerships.
- Nepal's political crisis continues,[1] but the Nursing Association and ob/gyn associations have oriented the Nursing Board and trained more than 80 people to practice AMTSL and to motivate others to do the same in four regions of Nepal.
- More than 2,300 job aides (English and French) have been distributed globally (poster and fact sheet); a draft training model is developed; and French and Spanish CD-ROMs are under production.

[1] Continues from Jan 2006 to date

- POPPHI, with partners in Mali, is leading "cutting edge" work to train auxiliary providers to use AMTSL.
- Tracking and publicizing the latest research and findings has kept PPH prevention (AMTSL and misoprostol) in the international media; with increased interest and programmatic activities globally.

Figure 1 presents a summary table of performance and illustrates that POPPHI has again met or exceeded all of its targets for this reporting period.

Task 1: Expand AMTSL through nontraining approaches to improve provider practice

During this reporting period, there has been a significant focus on advocacy and policy development with regard to important issues on PPH prevention and AMTSL. POPPHI accomplished this through dialogue and collaboration with partners and potential partners; numerous presentations on PPH prevention and management and AMTSL; meetings and conferences; development or assistance with policy briefs; and Web site and online activities. These efforts have reached out to international organizations (WHO, United Nations Children's Fund [UNICEF], and United Nations Population Fund [UNFPA]), countries (including Mali, Indonesia, Ghana, and Uganda), professional associations, nongovernmental organizations (NGOs) (e.g., SAVE, CARE, and the umbrella organization for NGOs, CORE), to provide the latest information on successful programs and the latest research findings. POPPHI has solidified and expanded partnerships with the Africa 2010 project and RPM Plus to have a more significant impact. Particularly important are POPPHI's leadership and contributions to the practical guidance on Oxytocics meeting, the Goa conference, the Entebbe conference, the development of a second joint statement on the prevention of PPH in low-resource settings, and the upcoming WHO Technical Consultation on PPH to be held in Geneva October 18–20, 2006.

The PPH Working Group is another mechanism to share new, cutting-edge and sometimes controversial data with colleagues working in related fields. POPPHI hosted its second PPH Working Group meeting in March 2006. The meeting provided data from just-completed National Institutes for Health studies and data from new international research projects. Clinicians and researchers from developing countries attended, and the presentations led to discussions and agreements on important activities to pursue, new research topics and ways to collaborate on PPH prevention and management for maximum benefit to the field. The Task Forces (TF) carried the momentum forward and addressed specific topics that were identified either in the PPH Working Group or by TF members such as the revision of the PPH Toolkit, development of the training module, issues around misoprostol, and oxytocin in the Uniject™ device, including the use of a vaccine vial monitoring-type device.

Nontraining approaches to improve provider practice also included material development such as the job aids: a poster, including an 8 by 11-inch version, and a fact sheet (see

additional information under Task 2) in English, French, and Spanish; training module; French and Spanish CD-ROMS; practical guidance synopsis, all of which have been printed, distributed, and/or posted on the Web site when finalized. The global AMTSL survey questionnaires with commentary, protocols, sampling plan, and other related documents will be available on the Web site in the next 6 months. Additionally, 729 condensed PPH toolkits, 199 Reference PPH toolkits, and 421 English-version CD-ROMS were distributed to people from 15 countries during the last 6 months (Feb–July 2006).

The national-level professional associations that received small grants are taking leadership roles in their countries in the prevention of PPH by working on training, advocacy, and policy issues, including working to include oxytocin as the first-line drug and on the essential drug list (EDL). POPPHI works continuously with these grantees to ensure high-quality training and work. POPPHI provided materials (posters and fact sheets for policymakers) to the small grant recipients. In addition, POPPHI brought policymakers from six countries (Ethiopia, Mali, Uganda, Tanzania, Ghana, and Malawi) to the Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice conference in Entebbe, Uganda, on April 4–7, 2006, in order for them to both present their own work and receive updates on PPH-related topics. National association partnerships that seem to be making an impact include Nepal, who has trained more than 80 nurses and physicians in four regions of Nepal; the Dominican Republic associations who have developed a public–private partnership and obtained donations of oxytocin from suppliers to use in their hospitals; Malawi, who has trained a total of 37 participants from 22 districts and from five midwifery educational institutions.

Task 2: Improve the quality and availability of AMTSL at the facility level

The AMTSL global survey continued to be a focal point during this period; and surveys are planned, ongoing, or waiting concurrence or funding in Nicaragua, El Salvador, Guatemala, Honduras, Indonesia, and Uganda. Costa Rica also organized and paid for its participation in the global survey. RPM Plus has been involved in conducting surveys in the West African countries of Benin and Mali. Benin is awaiting International Review Board (IRB) approval but is ready to begin. Mali was originally planned to begin during this reporting period; however, the Ministry of Health (MOH) decided to postpone this activity for at least 6 months to allow for additional AMTSL training to occur.

The Tanzanian and Ethiopian surveys have been completed; the data analyzed; and the report is in final stages of editing. Data from these surveys were presented to the East, Central, Southern Africa Health Community, Family, Reproductive Health Programme (ECSA) Commonwealth Ministry of Health meeting in the first quarter of 2006; the Entebbe conference in April; and the Goa conference in July; data will be presented at USAID/Washington in August 2006. All opportunities were taken to share this data in order that countries could learn from it. Tanzania utilized the data as they prepared it an action plan at the Entebbe conference. Additionally, Dr. Sylvia Deganus, from the

Ghanaian delegation, gave the wrap-up comment at the Entebbe conference and stated that Ghana was going back to reevaluate its use of AMTSL, given the data presented and lessons learned from the Ethiopian and Tanzanian surveys.

In addition to the global survey, POPPHI's work in Latin America focused on two areas: (1) small grants to Bolivia, Peru, Paraguay and Dominican Republic; and (2) work with three midwifery/nursing associations from Bolivia, Ecuador, and El Salvador for follow-up to the International Confederation of Midwives (ICM) Trinidad conference in April 2002. For the small grants, the Dominican Republic has completed the majority of its activities, but Bolivia has two remaining training programs to complete. POPPHI consultant, G. Metcalfe, completed needs assessment visits to El Salvador, Bolivia, and Ecuador to support the Trinidad follow-on work (see Appendix A for trip reports). In addition to the assessments, the consultant worked with them to draft a proposal for a small grant to continue their work on PPH prevention and AMTSL.

Additional work under Task 2 included work with USAID and partners to revise and finalize the two outcome indicators and to work towards an internationally accepted indicator for AMTSL. This will include getting agreement on ways to collect data on the indicators. POPPHI and its partners have also been in dialogue with USAID and countries regarding the need to scale up and expand the use of AMTSL in at least five countries (with three countries including a community-based approach). The MOH and USAID in Mali have agreed to scale up AMTSL and plans are being finalized with Benin, Ghana, Indonesia, and Uganda. Another activity that has been completed and will be submitted to USAID during this period is the training evaluation.

Six new job aids were completed during this time period, including a poster on AMTSL and a fact sheet for policymakers; both are available in English, French, and Spanish. Almost 2,000 each of the English poster and fact sheet and 325 of the French poster have been distributed; all six job aids are available on the Web site.

Task 3: Improve the quality and availability of AMTSL at the community level

POPPHI received additional core funds (US$100,000 per country) in the previous period to support the expansion of active management in three countries by working in collaboration with USAID-supported bilateral projects. Activities are underway with bilateral programs in Indonesia, Mali, and Pakistan. Bangladesh is a fourth bilateral program, collaborating with POPPHI on PPH prevention activities, with the work facilitated by EngenderHealth. **Mali** will implement a demonstration project where midwifery assistants (*matrones*) will be trained and supervised to perform AMTSL and evaluated for safety and feasibility. Partners include the bilateral project (Assistance Technique National [ATN]), IntraHealth/The Capacity Project and CARE/Keneya Ciwara project. IntraHealth/Capacity Project received an additional $100,000 to contribute to this project. In early April 2006, D. Armbruster visited Mali to meet and work with partners, including USAID and the MOH. In May, POPPHI consultant S. Engelbrecht visited Mali to finalize the work plan/proposal, meet local partners, and plan

for trainings (see Appendix B for trip report). The first workshops are planned for the beginning of September 2006. In **Indonesia**, the bilateral funds are being used to complete the global survey, to be followed by a dissemination workshop and follow-up initial activities to increase use of AMTSL based on survey findings. A stakeholders meeting was held, IRB approval received, training of data collectors completed, and data collection has started. **Pakistan** will hold a national dissemination meeting on AMTSL in October 2006, followed by four provincial workshops. The work in **Bangladesh** is supported through POPPHI's partner EngenderHealth (EH). EH has a bilateral project in Bangladesh and is holding a national stakeholders meeting August 30–31, 2006, as well as incorporating work on AMTSL in three hospitals in Bangladesh.

In addition to work of the Community-based PPH Prevention Task Force (who met in March 2006), POPPHI is also developing a community-based indicator to use in monitoring and evaluation activities.

Task 4: Make Uterotonic Drugs and Devices (UDD) available at low cost to countries

POPPHI recognizes that there is grossly inadequate information provided to the field (e.g., to district hospitals, health centers, and clinics, as well as MOH personnel) on how to use, manage, and, in particular, store oxytocic drugs. Therefore, POPPHI held a meeting on March 21, 2006, to address these issues on oxytocics. This meeting brought together Essential Drug and Making Pregnancy Safer departments of WHO, United States Pharmacopeia (USP), International Dispensary Association (IDA), USAID, manufacturers of oxytocin, and program implementers to provide practical guidance to the field on the use, storage, and management of oxytocics, particularly focused on oxytocin as the first line drug for use in postpartum hemorrhage prevention and treatment. The following primary issues were addressed: the research data indicating that oxytocin can be stored without refrigeration for up to 3 months at up to 30°C, and changes in labeling to allow oxytocin to be used as far out to the periphery as possible. Additionally, POPPHI is following up on renewed interest in delivering oxytocin in the Uniject™ device. POPPHI met with representatives of Becton Dickinson, owners of the patent and producers of the Uniject™ device, in Goa, India, in July 2006. During the meeting of the International Congress in Goa, there was much interest among countries and international organizations for oxytocin in the Uniject™ device to be made available for use, particularly when the data indicated that it was as cheap or cheaper than misoprostol (in India per the Goa data).

POPPHI is also working with PATH's HealthTech program on the possibility of Vaccine Vial Monitors (VVMs) for oxytocin, which was discussed at the meeting in March.

1.2 Looking to the Future

POPPHI plans to focus on scaling up and expanding the use of AMTSL in five countries and addressing community-based PPH prevention activities in three of those countries

during year 3, August 2006–July 2007. A strategy will be developed to support the guidelines developed in Goa, including community-based misoprostol, in collaboration with USAID. Next steps include taking the information from the meeting and making them available to people in the field via the Web site and list-serv. Advocacy and policy change will remain significant components of POPPHI's work, particularly work with WHO on the technical consultation and the follow-up to the Practical Guidance on the Use, Management, and Storage of Oxytocics meeting. One new area that POPPHI will explore is the use of behavior change interventions to increase the use of AMTSL and other PPH prevention activities, including the possibility of national campaigns directed at both providers and women. The international AMTSL survey will be completed in 10 countries and the focus will be on disseminating and using that data to make changes at country level.

1.3 Activities Completed by Task

General

Under this category, all activities listed in this period are either ongoing or completed. Activities include the following:

- In addition to updating sections, the following new items were added to the POPPHI Web site (www.pphprevention.org): information on PPH prevention indicators; job aids (including RPM Plus job aids); presentations from the PPH Working Group, POPPHI Task Forces, and meeting on Practical Guidance on Use, Management, and Storage of Uterotonics; and updates on the small grants activities.
- POPPHI initiated a list-serv on PPH prevention on March 7, 2006. This list-serve provides an opportunity for members to share information and for the POPPHI project to share and ask for comments and suggestions on topics of interest. The Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) project became a collaborator on the list-serve in July 2006, and sent invitations to the participants of the Entebbe meeting, Preventing Mortality from PPH in Africa: Moving from Research to Practice, to join the list-serv. ACCESS is currently evaluating the possibility of providing French translation for the list-serv.
- Maintain master calendar of events.
  - This calendar is available online and is an ongoing activity with participation by all partners. The majority of the following conferences and meetings are listed and have been attended by POPPHI staff:
    - A PPH Working Group meeting was held on March 20, 2006; and was followed by TF meetings on first interventions, training, community-based PPH prevention, and UDD. These meetings brought together experts in the

field to share information and provide guidance to USAID and POPPHI on issues related to the prevention of PPH.

- POPPHI continued to meet with Private Sector Partnerships-*One* (PSP-*One*) project to provide guidance and determine ongoing areas of collaboration. POPPHI's director gave an interview for PSP-*One's* Web site (available at: http://www.psp-one.com/content/announcements/detail/2926/).
- POPPHI was a partner and sponsored the Entebbe conference: Preventing Mortality from Postpartum Hemorrhage in Africa: Moving from Research to Practice. It was held April 4–7, 2006. More than 150 participants from 22 African countries attended and simultaneous French translation was provided.
- A meeting on Prevention and Treatment of PPH: New Advances for Low-Resource Settings was held at the American College of Obstetricians and Gynecologists (ACOG) on May 8, 2006. A draft joint statement on this topic was developed for presentation at the International Federation of Gynecology and Obstetrics (FIGO) conference in Malaysia in November 2006.
- A meeting was held with USAID and cooperating agencies (CAs) on June 27 to identify ways to increase the use of the PPH prevention indicator on AMTSL. Suggestions were made to revise the indicators for ease of use. Indicators have been shared on the list-serv for comments.

- Facilitate the exchange of information and coordinate with implementing partners (IPs).
  - At the request of USAID, POPPHI assisted in coordinating teleconferences with multiple organizations and colleagues interested in PPH prevention in low-resource settings to continue sharing of data and information.
  - The POPPHI partners, RTI, EH, and PATH hold monthly teleconferences where they share information on project activities, discuss issues and concerns, and plan future activities. This is a very effective mechanism to keep the partners located in different cities updated and communicating on POPPHI's status and moving forward on work plan activities. During this period, ICM and FIGO became regular members of these monthly teleconferences.
  - RTI staff member, Niamh Darcy, contacted and worked with the IPs (particularly ACCESS) to collect data on the summary outcome indicators. The Quality Assurance (QA) Project has also shared data from its collaborative work in Benin, Ecuador, Honduras, and Nicaragua.
  - POPPHI director met with ACCESS staff, Koki Agarwal and Patricia Gomez, to discuss upcoming work plans and how to maximize results and success for

both projects. Additionally, the projects collaborated on the Entebbe conference, the translation of the CD-ROMs, toolkit distribution, ACOG, and New Delhi (June 2006) and Goa meetings.

  - Health Tech and POPPHI have extensively collaborated on the Practical Guidance on the Use, Management, and Storage of Uterotonics meeting, with RPM Plus staff contributing fact sheets on oxytocin and uterotonic drugs.

- Identify and track current and ongoing research and country implementation related to AMTSL.
  - A list of ongoing research on misoprostol for preventing PPH is available on the POPPHI Web site. The information was updated in July 2006.
- Convene a PPH Working Group Meeting.
  - See above first bullet under Maintain Calendar of Events.

Reporting

- The POPPHI year 3 draft workplan for activities in Latin America and the Caribbean (LAC) was submitted in July 2006.
- Work has begun on the year 3 workplan and budget, and updated Performance Management Plan due in September 2006.
- POPPHI submitted its August 1, 2005 to January 31, 2006 semi-annual report to USAID on schedule.

Task 1: Expand AMTSL through Nontraining Approaches to Improve Provider Practice

Provide technical assistance to FIGO and ICM to promote the use of AMTSL

1. Continue dissemination of FIGO/ICM Joint Statement

- Assist FIGO and ICM staff to facilitate dissemination of joint statement through their meetings.
  - POPPHI has provided PPH toolkits, FIGO/ICM joint statements, briefing papers, and job aids for the Entebbe meeting, Global Health Council, Goa meeting, and the New Delhi meeting.
  - The Philippine midwifery association is hosting an international midwifery conference in October 2006 and POPPHI will provide toolkits, FIGO/ICM joint statements, briefing papers, and job aids for their participants.
- Organize dissemination of technical materials, including PPH toolkit, to associations. Create a distribution list.
  - Continued to disseminate toolkits to associations at the Entebbe workshop.
  - Distributed 100 copies of the job aids (poster and fact sheet) in either French or English to all associations attending the Entebbe workshop (Ethiopia, Ghana, Malawi, Mali, Tanzania, and Uganda).

  - POPPHI sent the Indian ob/gyn association (FOGCI) 100 copies of the poster.
  - Created a distribution list for the job aids (see Appendix C).
- Review and potentially revise joint statement
  - No revision was made to the current joint statement on *Management of the Third Stage of Labour to Prevent Postpartum Haemorrhage.* A draft second joint statement was developed for consideration by FIGO and ICM, entitled: *Prevention and Treatment of PPH: New Advances for Low-Resource Settings.*

2. Provide technical assistance (TA) to associations for workshops on PPH

- Use AMTSL training materials and practica appropriate for workshop settings.
  - CD-ROMs are currently being translated into Spanish and French for distribution to association colleagues.
  - Packets of relevant material and articles, including a skills checklist on AMTSL are provided in all workshop settings. A childbirth anatomical model is also used for demonstrations.
- Identify and adapt nontraining approaches to increasing provider skills on AMTSL.
  - POPPHI's Web site (www.pphprevention.org) is live and updated on an ongoing basis. POPPHI has been informed by numerous national association colleagues that the Web site is used routinely, easy to use, and informative.
  - Distribution of the Pan-American Health Organization–translated condensed version of the PPH toolkit is ongoing.
- Identify and utilize representatives and experts from countries in each region with experience in AMTSL to take leading roles and to assist small grant recipients and other countries interested in introducing AMTSL.
  - Dr. Ashebir Getachew will serve as a consultant to assist the Uganda AMTSL survey team to lead the orientation with the questionnaires and provide assistance as needed with administration of the survey and data collection.
  - Gloria Metcalfe, Chilean midwife, is serving as a consultant for the Trinidad follow-on work.
- Link with regional experts trained by the Maternal and Neonatal Health (MNH) program and with national associations.
  - Kezia Kapesa, a midwife from Tanzania and an MNH-trained master trainer, participated in the PPH Working Group meeting on March 20, 2006, and the meeting on the Use, Storage, and Management of Oxytocics on March 21, 2006. Ms. Kapesa is also invited to the WHO Technical Consultation in October 2006.
- Provide association leadership with evidence supporting the use of AMTSL to ensure commitment to AMTSL. Provide training as needed.

- Association leadership who are part of the small grants in 16 countries has been provided this information. Completed.

- Facilitate and assist associations to implement, evaluate, and follow up on workshops/practice, using expertise from a master resource list and IPs.
  - This work is ongoing.

3. Provide assistance, monitoring, and evaluation of small grants

- Award approximately 12 grants in year 2.
  - All 16 grants were awarded and all grantees, except Peru and Paraguay, have received their funds and are completing baselines or implementing activities. Visit http://www.pphprevention.org/small_grants.php for more information.
  - Baseline surveys were received from seven countries—Benin, Uganda, Nepal, Bolivia, the Dominican Republic, Pakistan, and Malawi (some of these countries will submit additional baseline data as trainings are completed; we are following up with these countries and collecting the data as it becomes available.) Remaining countries will report data when scheduled activities are completed.
- Monitor progress of grants, in collaboration with FIGO and ICM.
  - The tracking tool has been revised to include updates on project activities.
  - N. Darcy, M&E specialist, created a database for input of baseline (and endline) survey data from the small grant awardees/national associations. She is in the final stages of hiring an intern to assist with data entry and managing this database. Ms. Darcy will supervise the intern at RTI.
  - C. Kramer and M. Greeley have added phone calls to their armamentarium of M&E tools. The calls facilitate movement on activities and reporting.
  - Discussions have been held with FIGO related to difficulties with the Paraguay ob/gyn association.
- Provide materials and selective TA to grantees to ensure high quality and competence in AMTSL training.
  - TA has been provided by consultant, G. Metcalfe, and there are plans for D. Beck to assist with standardization of the practice of AMTSL for association trainings in Bolivia, Ecuador, El Salvador (Metcalfe) and Pakistan (Beck).
- POPPHI supported the presidents of six ob/gyn and midwifery associations from Ethiopia, Ghana, Malawi, Mali, Tanzania, and Uganda to attend the Entebbe conference in April 2006.

4. Promote the publication of the FIGO/ICM joint statement in 25 association newsletters or other mechanisms

- Ensure ICM and FIGO publish joint statements in 25 national newsletters (or other mechanisms).

– Completed.

5. Distribute PPH toolkit

- Distribute toolkits through regional and national medical, midwifery, and nursing professional meetings.
  - POPPHI distributed numerous PPH Toolkits to date at conferences, meetings, and at the request of interested parties. During this period, 729 (plus previous 1,006, for a total distribution of 1,735) condensed PPH Toolkits, 199 (plus previous 386, for total distribution of 585) PPH Toolkit reference manuals, and 421 (plus previous 579, for a total distribution of 1,000) CD-ROMs were distributed in 15 (for a total of 80) countries (see Appendix D for distribution list).

6. Link or collaborate with other organizations to expand the use of AMTSL

- Work with UNFPA, UNICEF, and WHO to develop a joint statement in support of AMTSL.
  - A technical meeting on the prevention of PPH, with a focus on AMTSL, is scheduled for October 18–20, 2006, in Geneva.
  - WHO has written a memorandum supporting the use and expansion of AMTSL and has sent it to WHO field offices.
- A meeting of CAs was held on June 27, 2006, with the participation of USAID and 10 organizations, to increase the use of the AMTSL indicators for tracking AMTSL data.
- M. Greeley attended the April 2006 CORE meeting and the Safe Motherhood/Reproductive Health Working Group, provided updates on PPH Prevention and POPPHI activities, and distributed POPPHI materials.
- D. Armbruster provided updates on PPH prevention and management, including misoprostol, to the annual Save the Children retreat in June 2006, with program managers from around the world.

7. Monitor activities of professional associations in promoting AMTSL

- Assist FIGO and ICM to track member association information dissemination activities to promote AMTSL policies and practices.
  - A database for tracking data from associations is completed (see Appendix E).
  - FIGO has continued to collect data through its survey of ob/gyn associations and several midwifery associations. See http://www.sogc.org/figosurvey/index_results.asp for available results.
- Periodic teleconferences are held with ICM and FIGO to update all parties on accomplishments and address issues. POPPHI holds regular teleconferences that occur once every 1–2 months with all partner organizations.

- USAID and others may refer to the POPPHI Web site to get periodic updates and current information on the status of POPPHI's work promoting AMTSL.

Task 2: Improve Quality and Availability of AMTSL at the Facility Level

1. Evaluate training and nontraining approaches designed to improve provider skills in AMTSL

- Document and evaluate traditional and nontraditional skill-building approaches to measure its effectiveness in ensuring essential competencies related to AMTSL.
  - This work is ongoing.
- Develop an evaluation report of training strategies.
  - The training evaluation has been completed and will be included in the Aug 2006–Jan 2007 semi-annual report.
- Hold a training TF meeting.
  - Training TF met for the second time on March 20, 2006. Since then, TFs have been actively involved in reviewing a training module that was developed and will be included in the revised toolkit.
- Evaluate the self-study module.
  - The self-study module is on hold until the training module is completed. We will then evaluate the need for the self-study, particularly given the amount of material that is available on the Web.
  - POPPHI is evaluating the possibility of developing, in collaboration with IntraHealth (Mali) and/or Pakistan, a mentoring system as an alternative training strategy. This would likely use self-study material first, and then practitioners would obtain clinical experience at a designated "mentoring" facility.
- Share training materials.
  - A draft training module for participants has been completed. Selected components of the module (e.g., the skills checklist), is being pretested in Pakistan during a standardization meeting held with the small grant awardees. Additionally, the module will be used, in combination with materials developed under the previous PPH initiative in Mali for training of pharmacists and *matrones*.
  - Job aids have been distributed widely: all associations attending the Entebbe conference received packages of 100 posters; other participants in Entebbe; CORE group members at their annual meeting; Global Health conference participants; Delhi MotherNewBornNet meeting participants; and Goa meeting participants. The following countries have received hard copies of the job aids: Afghanistan, Angola, Bangladesh, Benin, Burkina Faso, Cambodia, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Indonesia,

Kenya, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nigeria, Philippines, South Africa, Tanzania, Togo, Uganda, Zambia, and others throughout the Asia region. EH led the production effort, and assisted significantly with distribution. The job aids are also available to download on the Web site.

2. Develop monitoring plan; measure implementing partners' progress toward achieving benchmarks and measure availability and coverage of AMTSL services

- Finalize M&E plan to monitor IP programs' progress toward achieving benchmarks and measure availability and coverage of AMTSL services in five countries.
  - This step is completed.
- Revise M&E plan as needed, based on input from USAID and IPs.
  - Work has continued on revising two outcome indicators. With comments and suggestions from the CAs meeting in June, final revisions have been made and any last comments are requested through the POPPHI list-serv (end date August 18, 2006).
- Collect needed data on benchmarks and indicators and provide periodic progress reports to USAID and IPs.
  - RTI staff continue to facilitate data collection of indicators from IPs. POPPHI staff collect data from the small grant recipients.
  - Information on the indicators are available on the Web site at http://www.pphprevention.org/Indicators.htm

3. Provide TA to missions and regional bureaus upon request

With support from the LAC Bureau, POPPHI is working with midwifery associations that attended the Trinidad regional ICM workshop in April 2002 so that they can build on their activities to expand the use of AMTSL. POPPHI received three responses to its request for follow-up information to the action plans developed by midwifery associations in Trinidad. Bolivia, Ecuador, and El Salvador responded and then received assessment visits from Gloria Metcalfe, POPPHI consultant. These countries are now in the process of finalizing proposals for the additional activities for approximately US$8,000 each.

Additionally, POPPHI worked with REDSO-East, Africa Bureau, the SARA Project, ECSA, and the Regional Centre for Quality Health Care (RCQHC) to complete the AMTSL survey in Ethiopia and Tanzania. The final reports are currently under review. Uganda has been selected as a third country and preparation/orientation is underway to complete the survey in Uganda.

- Work with ob/gyn societies in Central America to increase support for the use of AMTSL by skilled providers.

  - Cindy Stanton and Gloria Metcalfe visited El Salvador to orient the researchers from Costa Rica (participating with its own funds), El Salvador, Guatemala, Honduras, and Nicaragua to the protocols, questionnaires, and plan for survey activities.
  - The subcontract will be with the El Salvador ob/gyn association to facilitate ease of access to funds related to Dr. Jarquin's (from El Salvador) coordination role and connection to the El Salvador association.
- Participate in the small grants program to support national ob/gyn and midwifery associations in Latin America.
  - The Dominican Republic has moved forward rapidly with its training and has developed a public–private partnership with the suppliers of oxytocin to ensure the availability of the drug to its hospitals. Bolivia has conducted one training but delayed the next two trainings because of gross inflation of airline costs and need for additional funds (approved and pending signature on amendment).
- The global AMTSL survey to assess current practices regarding AMTSL and to identify major barriers to its use has been completed in Ethiopia and Tanzania. A dissemination workshop was held in Ethiopia, but it was not well attended. Additional dissemination workshops are planned for both countries, with assistance from ECSA. The final reports from both countries are being finalized. The survey is currently being completed in 8 other countries, for a total of 10.
  - Dr. Ominde Achola, ECSA staff, presented information on the AMTSL survey to the ECSA MOH during the 42 annual regional meeting on February 6–10, 2006.
  - Drs. Ashebir Getachew and Sayoki Mfinanga presented the AMTSL survey data at the Entebbe conference on April 4–7, 2006, with A. Mutungi and O. Achola. The presentation was well received, and data on Tanzania were used by the Tanzanian team to develop its country action plan.
  - Dr. Ashebir Getachew presented the AMTSL survey data at the International Congress in Goa on July 12–15, 2006.
  - The Uganda survey was approved, and the in-country survey activities will be funded through the Africa 2010 project; anticipated start date is August 2006. Dr. Ashebir Getachew will provide assistance to Uganda as a POPPHI consultant.
  - The Central American study awaits approval of its subcontract and is ready for the data collection phase. Countries participating are El Salvador, Guatemala, Honduras, and Nicaragua. Costa Rica will participate in the survey at its own expense, as POPPHI did not have funds for an additional country. Panama, though interested, was unable to participate because of a lack of funds.

  - POPPHI is collaborating with its partner RPM Plus in West Africa. Dr. Sourou Ghangbade is the coordinator for this effort. Benin and Mali were chosen as countries to complete the global survey, although the Malian MOH has asked to delay its participation until approximately 6 months from now in order for additional training in AMTSL to take place in Mali. Benin is finalizing the ethical approval and will begin data collection in August 2006.
  - The AMTSL survey is being conducted in Indonesia under a bilateral agreement with the Health Services Program project and agreement by USAID. The survey will be conducted by the PATH office, and Iwan Ariawan will serve as the in-country coordinator.
  - The results of the Ethiopia and Tanzania survey will be presented at the Maternal and Newborn Technical series at USAID by Cindy Stanton and Debbie Armbruster on August 4, 2006.
  - FIGO Congress (November 2006): C. Stanton will give a presentation on the data from six countries in the international survey, in conjunction with Dr. Getachew and Dr. Jarquin. Dr. Lalonde (FIGO) and K. Herschderfer (ICM) will co-chair the one and one half hour session and Dr. Festin (WHO) and Dr. Mathai (WHO) will be discussants.
- Translate CD-ROMs
  - Translation of the CD-ROM into both Spanish and French is currently underway. The text has been translated into each language and a production company has been identified. The CD-ROM will be available for posting on the Web site in each language, and 1,000 of each CD will be reproduced. The Web-ready version is scheduled for completion by August 31, 2006. At the request of JHPIEGO, the translations were also reviewed by its staff.
- Translate the Job Aids
  - See the previous section "Evaluate training and nontraining approaches."
- Conduct follow-on to Trinidad ICM conference.
  - G. Metcalfe traveled to El Salvador in February 2006 and Bolivia and Ecuador in April 2006 to conduct assessments in each country. G. Metcalfe worked with groups in each country to develop proposals for follow-on activities to the Trinidad action plans that will total no more than US$8,000-10,000 (see Appendix A for trip reports).
- Collaborate with the QA Project
  - POPPHI has identified the Bangladesh bilateral effort, with EH in the lead, as an activity for collaboration with the QA project or for use of a similar computer tracking system of provider performance.

Task 3: Improve the Quality and Availability of AMTSL at the Community Level

The POPPHI project continues its interest in identifying ways to assist women at the community level to prevent and/or treat PPH. POPPHI has supported, technically, administratively and financially, several meetings and conferences that address community-based issues, particularly the research and use of misoprostol. The community-based TF is also making contributions to this effort.

- An article on community-based AMTSL was written and is under review for the MotherNewborNet newsletter; the article will be included either as an article or as a hot topic on the list-serve.
- Additionally, POPPHI is monitoring research on the use of misoprostol for the prevention and treatment of PPH. Several meetings on PPH prevention and treatment in low-resource settings have been held, with POPPHI in a coordinating role. A meeting on May 8, 2006, at ACOG finalized a draft FIGO/ICM Joint Statement on this topic (see Task 1).
- POPPHI provided US$25,000 in funds and input for the International Congress held in Goa, India on July 12–15, 2006. The conference reported on a large, randomized placebo-controlled trial of community-based use of misoprostol and found a significant difference in PPH between misoprostol and the placebo group.
- The TF on community-based PPH prevention had its second meeting in March 2006 (see http://www.pphprevention.org/TaskForces.htm#March2006). The TF recommended that POPPHI conduct a literature search on community-based prevention of PPH activities. This is currently underway.

1. Develop monitoring plan; measure IPs' progress toward achieving benchmarks and measure availability and coverage of AMTSL services

- Collaborate with IPs on indicators, sources of data, reporting procedures, etc.
  - Completed.
- Revise M&E plan as needed, based on input from USAID and IPs.
  - Completed.
  - Two outcome indicators were reviewed and revised; CA meeting on June 27 provided valuable feedback and interest from CAs and NGOs to track AMTSL with the indicators. Further review and comments are being solicited through the list-serve. Finalization is expected shortly.
  - Draft community-based indicators were developed and feedback is being solicited through the list-serve.
- Collect needed data on benchmarks and indicators and provide periodic progress reports to USAID and IPs.
  - Ongoing.

2. Provide TA to missions and regional bureaus upon request

POPPHI has identified four countries with bilateral programs that are interested in receiving TA from POPPHI to total US$100,000 per country: Bangladesh, Indonesia, Mali, and Pakistan.

POPPHI's work with the LAC Bureau continues as reported above (see "Provide TA to missions and regional bureaus upon request" under Task 2).

- Pakistan: In collaboration with the bilateral program, it was decided that the funds in Pakistan would be used for a national dissemination workshop that will be jointly hosted by UNICEF, UNFPA, the Pakistan MOH, and other organizations. Additionally, there will be four provincial workshops to give a more hands-on training to midwives and physicians at the district hospital and health center level. These workshops will be held in early October 2006. POPPHI met with N. Ali from the bilateral program and M. Skarie, USAID in New Delhi in July to discuss details for the national dissemination workshop. D. Armbruster will travel to Pakistan during late August 2006 to meet with the various stakeholders listed above and plan the October meeting.
- Mali: POPPHI is collaborating with the bilateral program, Assistance Technique Nationale (ATN), IntraHealth/The Capacity Project, and CARE/Keneya Ciwara to complete a pilot project that trains *matrones* in the use of AMTSL. The TA will also include an advocacy and policy intervention to promote the adoption of policies to allow the *matrones* to use oxytocin and perform AMTSL. D. Armbruster traveled to Mali in early April 2006 to meet with partners and to finalize the proposal: *Mali: Matrones and Oxytocin Project*. S. Engelbrecht, POPPHI consultant, traveled to Mali in May 2006 to meet with partners, finalize the workplan, and develop an analysis plan. Training materials are currently under development and the first training will occur in September 2006. The baseline survey will occur in late August 2006. The memorandum of understanding between all groups is ready to be signed; the subcontract between IntraHealth and PATH is in process.
- Indonesia: The bilateral funds for Indonesia are being used to complete the global AMTSL survey, which the PATH office will conduct. POPPHI met with L. MacLaren, deputy director of the bilateral project; Health Systems Project; and Sri Hermijanti Junizarman, director of Maternal Health, MOH-Indonesia in New Delhi, in July to discuss the possibility of Indonesia being a scale-up country. The MOH and the bilateral program were both interested in this possibility, and discussions will continue until details are finalized.
- Bangladesh: EH has agreed to use US$100,000 of its POPPHI budget to support PPH prevention work in Bangladesh. Activities will take place in three hospitals where EH is currently working and will include a simple QA process with computer-based data collection. D. Armbruster will travel to Bangladesh on

August 30–31, 2006 to participate in the stakeholders and advocacy meeting for these activities.

Task 4: Make Uterotonic Drugs and Devices Available at Low Cost to Countries

- It has been a busy 6 months for Task 4 activities. The Practical Guidance on Use, Management and Storage of Oxytocics meeting led to significant advocacy activities and policy shifts that maximize the use of oxytocin for PPH prevention. POPPHI's partners—WHO (both the Essential Drugs and the Making Pregnancy Safer divisions), USP, and manufacturers—have agreed to work together to see oxytocin moved as far to the periphery as possible. Uniject was seen as an important vehicle for providing oxytocin. Outcomes of the meeting included USP's agreement to change the monograph on oxytocin to allow use of the manufacturer's recommendation for storage (vs. 2–8°C). WHO discussed including oxytocin in its prequalification system. There was discussion of "overfilling" the ampoules to increase shelf life (see Appendix F for a synopsis of this meeting). RPM Plus developed two briefing papers on oxytocin and uterotonics for AMTSL which were widely disseminated during the Africa-wide Entebbe conference (see http://www.pphprevention.org/documents/OxytocininAMSTLflyer_03.29.06_Final.pdf; and http://www.pphprevention.org/documents/AMTSLUterotonicsflyer03.29.06_Final.pdf). As data from an important misoprostol trial became available, POPPHI was a major player in activities focused on misoprostol: the FIGO/ICM draft Joint Statement #2 meeting at ACOG on May 8, 2006, and the Goa conference where the data on the effectiveness of misoprostol compared to a placebo was presented. POPPHI continues to work closely with HealthTech on oxytocin in the Uniject™ Device issues and S. Brooke leads the UDD TF. POPPHI is also working more closely with RPM Plus to collaborate and complement each other's work. Additionally, RPM Plus has agreed to conduct full AMTSL surveys in two to three West African countries, utilizing research institutions in each of the countries. Data collection will begin shortly in Benin, and Mali plans to begin its survey in 6 months.

Convene the UDD TF

- A UDD TF meeting was held March 20, 2006.
- Detail barriers that affect international and national action.
  - The international AMTSL surveys are identifying barriers at country levels. Data from two East Africa surveys were presented at the Entebbe PPH conference in April 2006 and the Goa International Congress in July 2006.
  - The Practical Guidance meeting addressed several issues that are barriers to use of oxytocin such as labeling and storage requirements. Follow-up activities will address these issues.

- Misoprostol has several barriers to its use such as controversy over its effectiveness for PPH; not registered in any country for obstetric and PPH use; not available in country; and not on the EDL. WHO has not supported its use for PPH. A few of these barriers were addressed during the last 6 months: the Belgium study shows significant decrease in PPH, when compared to a placebo; Nigeria and Ethiopia have registered misoprostol for pilot purposes; and WHO has included misoprostol on the EDL, though for induction and abortion (25 µg). Additionally, the outcomes of the Goa conference include the willingness of WHO Making Pregnancy Safer department, to advocate for misoprostol being included in the EDL for PPH.

- Detail barriers that affect lower-level implementation.
  - Training: The lack of simple training materials that are competency-based impedes the ability of MOHs or NGOs to provide training in AMTSL for its health care providers. A draft participant training module for a two-day training is developed and under review by the Training TF. The Training TF is also making recommendations for revising the PPH toolkit. Job aids, the list-serv and the Web site are also ways that information is provided to clinicians and program managers to encourage the correct use of AMTSL.
  - Local logistics: POPPHI has developed a draft document on practical guidance for field use, management, and storage of drugs. The document was posted to the list-serv for comments and was discussed at the March 21, 2006, meeting on the use, storage, and management of uterotonics.
  - Provider and community acceptability: The AMTSL survey is looking at barriers to providing AMTSL to all women.

2. Conduct global survey on AMTSL

See *Task 2: Improve Quality and Availability of AMTSL at the Facility Level*; Bullet 3 Provide TA to missions and regional bureaus upon request

3. Convene a first intervention TF

- The first intervention TF had its second meeting on March 20, 2006 and a third meeting by teleconference on June 15, 2006. The next teleconference meeting is scheduled for August 2006.

4. Estimate and compare costs of uterotonics, injection equipment and devices, and cold chain storage of oxytocin

- Conduct a cost analysis.
  - Deleted from work plan after discussion with USAID.

By partnering with RPM Plus in a limited number of countries, POPPHI hopes to collect information on costs of uterotonics and injection equipment and devices and to identify ways to provide cold chain storage for oxytocin. POPPHI awaits the final report from

national-level surveys from five West African countries conducted by an RPM Plus consultant and will then share the information widely, ensuring that we work to assist countries to use this data to address barriers to use or expansion of AMTSL.

- Develop a policy brief, which UDD TF will lead, on cost-comparison of uterotonics, injection equipment and devices, and cold chain storage of oxytocin.
  - RPM Plus developed a policy brief on oxytocin and uterotonics in AMTSL.
  - Additional policy briefs are under discussion.
  - With the available data on the effectiveness of misoprostol and its cost, POPPHI will work with Health Tech and RPM Plus to develop a policy brief on cost-comparison of uterotonics. Either a separate brief or in combination, injection equipment and devices and cold chain storage of oxytocin will also be included.

5. Provide TA and advocacy to get drugs/devices registered for use in AMTSL in at least three countries

- POPPHI is evaluating the possibility of using oxytocin in the Uniject™ device in Mali. P. Paredes and others at USAID continue to advocate for and work to decrease the barriers to getting oxytocin in the Uniject™ device on the WHO Essential Drug List.
- HealthTech was included in the Goa conference. S. Brooke presented data from the Vietnam study on the use of oxytocin in the Uniject™ device for use in AMTSL. The possibility of oxytocin in the Uniject™ device was well received by conference participants, including WHO, and is included in country plans and conference recommendations.
- Discussions were held with Luc DeBernis, UNFPA Africa, who indicated interest in getting oxytocin in Uniject™ included in the UNFPA drug procurement system. Dialogue is ongoing.
- The Indian company Glandpharma is also attempting to produce oxytocin in the Uniject™ device. As requested, HealthTech is assisting in this effort.
- POPPHI developed a draft document on the *Use of Uterotonic Drugs for PPH in Tropical Climates: Guidelines for Essential Drug and Safe Motherhood Programs*. This document was posted to the list-serv for comment and served as the basis for discussions at the March 21, 2006, meeting on the Use, Storage, and Management of Oxytocics.
- POPPHI is working with USAID to focus on scale up in five countries that will include work on topics such as drugs, devices, registration, and regulatory legislation.
- POPPHI will utilize regional experts and consultants to provide TA and advocacy for drug registration and other drug-related issues.

1.4 Performance Standards Completed

The majority of the performance standards are discussed and covered under the narrative description of activities. We are still collecting data for our two outcome indicators, and when the global AMTSL survey is completed, we expect to have more detailed data for these two indicators. Table 1 summarizes the Performance Monitoring Report.

Task	Performance Standard	Year 2 Quarter 1	2	3	4	Actual; Date Completed	Target
0.1	Subcontracts with FIGO and ICM finalized			X		year 2 Amendment July 2006–FIGO ICM in progress	Yes
0.2	PPH Working Group (WG) meets 1–2 times a year	X		X		Second PPH WG met on 3/20/06	WG meets 1–2 times
1.1	Number of FIGO and ICM regional conferences where the Joint Statement on Prevention of PPH was disseminated			1		1 conference for 2006; Dec 2004 May 2005 July 2005 Sept 2005	Total of 4 conferences
1.2	Number of small grants to national professional associations for activities in support of increasing provider awareness and skills of AMTSL (see "Develop small grants mechanism" section)	14			2	16 issued through Aug 2006	Total of 16 issued
	Small grants effectively measure two or more of the agreed upon indicators					Baseline survey to associations: 7 completed[2]	16 countries
1.3	Disseminate the FIGO/ICM joint statement in 25 association newsletters or by other mechanisms	29/FIGO 24/ICM				FIGO and ICM Total of 53 statements disseminated; Jan 2006	25 newsletters or other mechanisms

[2] Note: We are still waiting for some summary baseline information from these 7 countries but the information is in transit to the US from the training sites

Task	Performance Standard	Year 2 Quarter 1	2	3	4	Actual; Date Completed	Target
1.4	1,200 toolkits distributed to professional associations Provide distribution list to ACCESS					1,735 condensed total, 585 reference total, and 1,000 CD-ROMs total; Distribution list developed sent to ACCESS; Aug 2006	Distribution strategy completed List of recipients developed
2.1	Evidence of joint work planning among implementing partners. Evidence in workplans of mutual agreements between the contractor and each of the implementing CA about roles and required nature and scope of support services	X	X	X	X	Second annual workplan; Dec 2005 WG meets once; Mar 2006 M&E plan revised; Dec 2005	2nd annual workplan of POPPHI PPH WG meets 1–2 times M&E plan finalized
2.2	Evidence of mechanism of coordination and collaboration among implementing partners	X	X	X	X	See 2.1 above	See 2.1 above
2.3	Evaluation report of training strategies		X			Completed and submitted	Evaluation scope of work completed
2.3a	Training TF meets 2–4 times a year		X			In progress Met in Mar 2006	Meets 2–4 times a year
2.3b	Job Aids developed	X	X			Completed and distributed to associations and numerous conferences	Poster, provider, and policy job aids
2.4	Evidence of functional monitoring system to measure progress of all implementing partners toward achieving benchmarks and to measure availability and coverage of AMTSL services		X	X	X	M&E plan revised; Dec 2005	Finalized M&E plan with agreed upon indicators
	Percentage of districts in a country with sites where service delivery staff have been trained in AMTSL and uterotonics (oxytocin) are available				X	See 1.5 below	No targets agreed upon
	Percentage of births in a specified time period in targeted facilities that				X	In progress	No targets agreed upon

Task	Performance Standard	Year 2 Quarter 1	2	3	4	Actual; Date Completed	Target
	receive AMTSL Results of survey available and used to develop intervention to increase support and use of AMTSL in Central American countries	X				Global AMTSL survey tools finalized and preparing to complete survey.	Completed survey and intervention initiated
3.1	Evidence of mechanism of coordination and collaboration among IPs	X	X	X	X	See 2.1 above	See 2.1 above
3.2	Evidence of functional monitoring system to measure progress of all IPs toward achieving benchmarks and availability and coverage of AMTSL	X	X	X	X	Consensus on performance monitoring plan and indicators among IPs M&E plan revised Dec 2005 Outcome indicators under revision Aug 2006	Finalized M&E plan with agreed upon indicators
3.3	Submit performance monitoring report		X		X	Semi-Annual Report; Aug 31 2006	Submit semi-annual report
3.4	USAID receives information on all IPs' progress toward achieving benchmarks and information on availability and coverage of AMTSL services		X		X	Semi-annual Report; Aug 2006	Submit semi-annual report
3.5	Provide TA to missions and regional bureaus	X	X			In progress	Provide TA
4.1	Critical pathway report completed					Yes; Dec 2004	Yes
4.2	UDD TF meets 1–3 times a year			X		UDD Task Force meets March 2006	Meets 1–3 times a year
4.2a	First Interventions TF meets 1–2 times a year			X		FI TF meets once; Mar 2006	Meets 1-–2 times a year
4.3	Number of countries where drugs/devices are registered (i.e., approved for use) for the indication of AMTSL in the correct dosage by government regulatory or policy-				X	See narrative, section 1.1.1.5.4	Report on work required to register drugs &

Task	Performance Standard	Year 2 Quarter 1	2	3	4	Actual; Date Completed	Target
	making bodies						devices
4.4	Number of countries with adequate cold chains established for storage of oxytocics					In progress—survey data will provide	Number of countries identified for year 1
4.5	Number of countries with adequate supplies of uterotonics in the drug procurement pipeline for routine use in all facility deliveries					In progress—survey data will provide	No targets agreed upon
4.6	Negotiation for field support or TA with at least two missions				X	In progress; Mali, Pakistan	Negotiation for field support or TA with at least two missions
4.7	Report on the cost-comparison of uterotonics choices					In progress	No targets agreed upon

Figure 1. Performance Standards Completed By Task

1.5 Additional AMTSL Performance Information

As we are still working to gain agreement on the finalized AMTSL outcome indicators 1 and 2, we have requested interim data from our CAs but have not received any updated information. Once we disseminate the updated outcome indicator definitions, we can work with our CAs to collect data semi-annually for both indicators.

Small grant baseline information

The POPPHI M&E team (Niamh Darcy and Michelle Torok) are in the process of finalizing our EpiInfo database. Once our intern, Michelle Torok starts (early September 2006), she will begin to enter data into this database so we can track and report on the data in more detail. The following data is provided for the seven countries that we have currently reviewed. Please refer to Appendix G for more detailed information.

(1) Nepal

There are 75 districts in the country. The small grant team targeted 48 facilities with their training activities. The small grant team targeted 64 midwives and 36 ob/gyns with their small grant activities.

We received summary baseline information from 71 midwives and 5 ob/gyns. For AMTSL

1. Administration of uterotonic drug within 1 minute of birth: 71
2. Apply controlled cord traction and counter traction to the uterus to deliver the placenta: 70
3. Massage the fundus of the uterus through the abdomen after delivery of the placenta: 68

We have not received the summary baseline information for indicator 1 yet.

(2) Benin

We received baseline information from 11 midwives and 4 ob/gyns for seven districts. For these districts, we have data for indicator 1, with percentages 59.7–100%, 84.6%, 91.3%, 86.5%, 100%, 100%, and 100% in the different districts represented.

(3) Uganda

There are 69 districts in the country. The small grant team targeted 8 facilities with their small grant activities.

They targeted 6 midwives and 6 ob/gyns with their small grant activities.

We received summary baseline information from 7 midwives and 2 ob/gyns. For AMTSL

1. Administration of uterotonic drug within 1 minute of birth: 3
2. Apply controlled cord traction and counter traction to the uterus to deliver the placenta: 5
3. Massage the fundus of the uterus through the abdomen after delivery of the placenta: 9

We received baseline information from 8 midwives and 0 ob/gyns for three districts. For these districts, we have data for indicator 1, with percentages 0–100%, 0%, and 100% in the different districts represented.

(4) Dominican Republic

There are nine districts in total in the country. The small grant team targeted 5 facilities with their small grant activities.

They targeted 55 midwives, and 55 ob/gyns with their small grant activities.

We received summary baseline information from 4 midwives and 13 ob/gyns. For AMTSL

1. Administration of uterotonic drug within 1 minute of birth: 15
2. Apply controlled cord traction and counter traction to the uterus to deliver the placenta: 9

3. Massage the fundus of the uterus through the abdomen after delivery of the placenta: 16

We received baseline information from 5 midwives and 14 ob/gyns for three districts. For these districts, we have data for indicator 1, with percentages 0–80%, Unknown, 0%-40%, 0%-50%, Unknown, 0%, and 0% in the different districts represented.

AMTSL Training Information

Please refer to Appendix H for more training details on dates and attendees.

Pass rate will be 90% for all programs conducting post-training assessments

Country	Training Targets	Detailed explanation of Training Targets	Actual End July 2006	Target End Sept 2006	Actual 2007	Target End Sept 2007	Post-training pass rate
Pakistan	250 (150 small grant, 100 bilateral)			175		75	For 100 participants
Nepal	80	4 regions x 20 participant per region = 80	82	80			For 75
Bolivia	115	(75 for small grants and 40 for the Trinidad Follow-on work)	31	75		40	
Peru	200			200			
Uganda	50			50			
Ethiopia	30	(20 tutors and 10 heads of schools)		30			For 30
Malawi	134	Train or update 29 SM trainers; 5 key persons in health training institute/ 100 clinical officers = 134	43	134			
Ghana	100		100	100			For 100
Tanzania	75	15 participants per municipality x 5 municipalities = 75	34	75			
Benin	90			90			
Mali	100	(25 small grant, 75 bilateral)		25		75	For 100
Cameroon	25			25			
Burkina Faso	25			25			
Paraguay	140			140			
Dominican Republic	200		23	150		50	
Ecuador	40					40	40
El Salvador	40					40	

Figure 2 Summary Training Information

1.6 Problems Solved or Still Outstanding

Scale-Up and Focus Countries

- POPPHI urgently needs to finalize the five scale-up countries (all five at the facility level and three of the five at the community level) and move forward with activities. Partners will to need to assist in this effort.

Small grant with Paraguay

- The Paraguay ob/gyn and midwifery associations were unable to finalize the grant agreement. Responses were only received from the midwives who suggested that they receive the grant directly. After discussing this issue with A. Lalonde, FIGO POPPHI is moving forward with providing the grant to the midwifery association.

Global AMTSL Survey

- The global AMTSL survey remains a challenge related to the time needed to manage it. Hiring A. Getachew to assist Uganda and potentially S. Gbangbade to assist with the data analysis workshop are some of the solutions used.

Data Collection

- Collection of data on the two outcome indicators is a challenge. There is very little data being provided by partners at this time. To try to solicit more data CA meetings are scheduled and other strategies are being employed.

1.7 Proposed Solutions to Ongoing Problems

- See above

1.8 Compelling Success Stories

1. Through multiple efforts, oxytocin is recognized as the drug of choice for AMTSL and is less stigmatized by its cold storage requirements through POPPHI efforts. These efforts include the Practical Guidance on the Use, Management, and Storage of Oxytocics meeting, which united important players in its effort to increase the use of oxytocin; focused messages in conferences and in policy briefs; and targeted information on the Web site and listserv.
2. The small grant awardees in the Dominican Republic have galvanized suppliers of oxytocin to donate supplies to hospitals in an excellent public–private partnership.
3. Nepal has continued in crisis during much of 2006 but the Nursing Association and ob/gyn associations have oriented the Nursing Board and trained more than 80 people to practice AMTSL and to motivate others to do the same in four regions of Nepal.

1.9 Documentation of Best Practices That Can Be Taken to Scale

AMTSL is a best practice, and this project seeks to take this best practice to scale.

Appendix A: Latin America and Caribbean Trip Reports

TRIP REPORT
Gloria Metcalfe, MNH –LAC/C Consultant
April 24–28, 2006
Trinidad Conference follow-up visit
BOLIVIA

Table of contents

Abbreviations

AMTSL:	active management of third stage of labor
EOC:	essential obstetric care
ICM:	International Confederation of Midwives
IU:	international units
JHPIEGO:	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MOH:	Ministry of Health
POPPHI:	Prevention of Postpartum Hemorrhage Initiative
PPH:	postpartum hemorrhage
SUMI:	Maternal and Infant Universal Insurance
WHO:	World Health Organization

EXECUTIVE SUMMARY

Prevention of Postpartum Hemorrhage Initiative (POPPHI) consultant visited Bolivia to meet with the two midwife participants of the Trinidad Conference in 2002, for reviewing the status of the active management of third stage of labor (AMTSL) implementation in the country according to its action plans. AMTSL has not been well, or completely, implemented in Bolivia. Although the procedure is mentioned in the National Norms from 2001, the protocol for this procedure has not been described, and the norms only mentions the use of 5 IU of oxytocin after shoulder delivery. Bolivia's national health insurance provides free

health care for mothers and newborns (*Seguro Universal Materno Infantil* [SUMI]), which includes free availability of 5–20 IU of oxytocin, depending on the level of health facility where birth occurs. Therefore, availability of oxytocin is not the issue; the issue is that doctors do not like to prescribe oxytocin.

According to the Ministry of Health (MOH), its AMTSL training program since 2001 has not been successful in long-term changes because doctors who have received the training will not replicate it for their colleagues without payment, which the MOH says they cannot afford. The doctors also refuse to adopt the AMTSL skills because they say they are "afraid of complications" like a "retained placenta." Most of the doctors have not been trained because the MOH and the doctors consider that AMTSL is a very simple procedure that does not require a special skill set. However, doctors do not regularly use AMTSL, and they have never been formally trained about the procedure.

The School of Nursing has included AMTSL in its preservice curriculum since 2001. However, practice with real patients is low in both in-service and preservice trainings. Nurses only attend births in rural areas (40% of all births in rural areas in Bolivia) or when doctors are not available (night shift). Nurses' roles are focused on supporting doctors, residents, and students when they are attending births and attending to administrative tasks. In preservice training, AMTSL is included, but practice is insufficient because competency-based methodology is not used, and opportunities to practice with real patients are very few. Nurses do not feel confident to practice AMTSL, and need to be properly trained in AMTSL by including a competency-based methodology in the preservice and in-service curriculum.

PURPOSE

1. Review plans of action from three midwifery associations that attended the ICM Trinidad workshop.
2. Meet in each country with midwifery leaders to
   - Review its plans of action;
   - Conduct an assessment of the use of AMTSL and the barriers to its use;
   - Assist each midwifery association to develop a proposal in each country (not to exceed $8,000–10,000 per country).

BACKGROUND:

POPPHI project, ICM and JHPIEGO/Baltimore conducted a conference in Trinidad to promote the use of AMTSL in 2002. Participants were nurses and midwives from Latin American countries who belong to nursing/midwifery associations in their countries. Based on the World Health Organization's (WHO's) international recommendations to decrease maternal and neonatal mortality, AMTSL and neonatal resuscitation skills were promoted and demonstrated during the conference, in addition to discussions about how to support the implementation of those skills in countries. Each country participant developed an action plan. Bolivia, Ecuador and Bolivia's participants reported advances implementing the use of AMTSL. Between January and April 2006, the three country's midwives and midwifery associations were visited to assess what had been done and identify follow-up activities to support the use of AMTSL in the country.

FINDINGS

1. Nurse Nancy Majon from the Bolivia MOH Maternal and Neonatal Health Unit in Sucre attended the Conference in Trinidad. She is currently in the same position. Since Trinidad, Nurse Majon included AMTSL in the content of one in-service training class for obstetricians and nurses in Sucre, sponsored by a POPPHI small grant.
2. The MOH is promoting the use of AMTSL since 2001, but changes have not been sustainable because of the training methodology and the noncompliance by doctors. The training is basically theoretical, and the practice of skills on anatomic models is poor and does not assure competency for trainees. Trainees do not have supervised practice with real patients. After receiving the training, trainees do not replicate the training to other staff in their respective facilities (no time or budget). The MOH and doctors don't believe that special training for AMTSL is necessary
3. The MOH norms state that AMTSL "should be done" and not **how** to do it. In addition, the norms state that 5 IU of oxytocin should be given after the anterior shoulder has been delivered.
4. The incidence of uterine atony is "high" (according to the Chief of the Maternity Unit of German Urquidi hospital in Cochabamba) and is mostly caused by PPH. In April 2006, this hospital recorded five hysterectomies due to uterine atony.
5. During the visit to the hospital in Cochabamba, the director of Sexual and Reproductive Health at the hospital, Dr. Angel Maida, acknowledged that the model they have for attending births is quite medicalized. He said, "Pregnancy and delivery can become a very complicated situation and must be attended by doctors." The majority of doctors have not been trained in the use of AMTSL, do not believe it is necessary, or are afraid to implement it for fear of "further complications." Essential obstetric care (EOC) training is not conducted in any institution in Bolivia, and nurses are not being trained in AMTSL.
6. Doctors are reluctant to change their practice because they lack practical experience; furthermore, doctors become an impediment for nurses who want to practice AMTSL because the nurses need a doctor's prescription for oxytocin.
7. The Trinidad participant from Cochabamba, Nurse Floida Montagno, told me that the nursing school of San Simon was having profound political changes that affected the entire function of the nursing curricula since the end of last year, which was her reason for not conducting any practical training in AMTSL (only theory).
8. Nurses and Nurse Auxiliaries do not regularly attend births (except when a doctor is not available on the night shift), have minimal opportunities to attend births during nursing school (they observe) and are not trained in the use of AMTSL (neither in-service or preservice).
9. Hoping to improve skilled birth attendance in rural areas, the University of San Simon (in Cochabamba) trained two groups of nurses in a 6-month diploma course in obstetrics (in 1995) without any impact, because nurses did not want to go out to rural areas to work (where they would attend births). Therefore, this training was discontinued.

CONCLUSIONS

1. The MOH supports the use of AMTSL in the norms, but has not updated the norms to reflect international standards (10 IU IM after the delivery of the baby, controlled cord traction, and uterine massage). They have not standardized AMTSL in preservice or in-service training programs, and do not require doctors to practice AMTSL.
2. Nurses do not feel competent attending births. Attending births is legally part of the nurses' professional role, and they occasionally do attend births as well as supervise students in practice, but they do not have practical skills training on AMTSL.
3. Although nurses and nurse auxiliaries do not regularly attend births (except on the night shift or in rural areas), they are the most stable personnel in the public health system.
4. Doctors are reluctant to change their practice because they lack the practical experience. Furthermore, doctors become an impediment for nurses who want to practice AMTSL because the nurses need a doctor's prescription for oxytocin.
5. Neither of the Trinidad participants feel competent in practicing AMTSL nor in leading trainings for this skill; they both said they needed more practice.

RECOMMENDATIONS

1. Support the MOH in developing a standardized clinical **training site** for EOC training.
2. Support the MOH in developing **a standard that describes how** to implement AMTSL based on updated international standards (WHO evidence based).
3. Nurses must be properly trained with skills practice, based on competency-based training methodology.
4. Doctors needs to be trained *together with* nurses in order to practice WHO-recommended practices for normal birth, including how to prevent episiotomy, receive and give immediate care to the baby, practice **the three steps** of AMTSL, and monitor the postpartum period.
5. POPPHI should revise the two remaining training sessions under its small grant funds to emphasize competency-based skills practice with models and real patients, assuring that the training takes place in a clinical training site that has been standardized in attendance of birth using AMTSL.

TRIP REPORT

Gloria Metcalfe, MNH –LAC/C Consultant

April 18–21, 2006

Trinidad Conference follow- up visits

ECUADOR

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Abbreviations

AMTSL:	active management of third stage of labor (MATEP in Spanish)
EOC:	essential obstetric care
FENOE:	National Federation of Midwives in Ecuador
MM:	maternal mortality
MOH:	Ministry of Health
PPH:	postpartum hemorrhage
POPPHI:	Prevention of Postpartum Hemorrhage Initiative
QAP:	quality assurance project
TA:	technical assistance
USAID:	United States Agency for International Development

EXECUTIVE SUMMARY

POPPHI consultant visited Ecuador to meet with the three midwives who attended the Trinidad Conference in 2002, for reviewing the status of the AMSLT implementation in the country according its action plan. Nurse Lourdes Pazmiño, one of the participants, continues to work in the MOH and Midwife Gloria Condor is the new president of National Federation of Midwives in Ecuador (FENOE) (since this year). The third participant, Alida Silva, from FENOE, is currently working at the Clinical Hospital and has not been involved in promoting AMSTL. Nurse Pazmiño and Midwife Condor, have been working to promote AMSTL along the QAP project since a couple of years ago and after the Trinidad Conference.

Midwife Regina Morales from FENOE, who attended the POPPHI Conference in Lima, has also been promoting, practicing and training AMSTL in the maternity where she works, despite the fact that the procedure was not included in the national guidelines. As a result of all these efforts, the MOH just launched (April 18) an amendment for the Reproductive Health National norms in

order to implement AMSTL as a mandatory procedure in all normal births, excepts in premature births, history of retention of placenta and accrete placenta.

According to data recently collected and although the MOH acknowledges that PPH is the main cause of MM in the country , there is still resistance from doctors to implement AMSTL, even from some MOH authorities and local experts. The MOH therefore wants to train doctors and midwives who attend births throughout the country as soon as possible. MOH asked for TA from the QAP project, and FENOE as well, to conduct this training countrywide. Funds from QAP project activities are still pending to be approved by USAID.

FENOE conducted a seminar about AMSTL on April 20 and QAP project was invited. 70 midwives from the regional associations of midwives participated. The MOH presented the situation of the maternal mortality in the country along with the National Strategy to decrease the MM, and the recently launched addendum of the National Norms regarding the implementation of the AMSTL. This consultant presented the evidence and use of the AMTSL, including a demonstration of the procedure. Midwives were very interested in receiving a training session in order to implement the procedure.

Midwives do attend births mostly in maternities, rural area health facilities, and when there are no residents or students in the birth rooms, however AMSTL has not been implemented and midwives do not feel confident to do it. Though the school Nursing has also included AMSTL in the preservice curriculum, proper practice of AMSTL has not yet been implemented. The health system is “medicalized” i.e. midwives don’t have autonomy for making changes.

The MOH wants to increase and encourage the role of midwives in MN care and expressed to FENOE that the role of midwives is key to improve the quality of care and decrease MM. The MOH emphasized its willingness to strongly support FENOE to improve its skills through proper training, and to increase the number of positions for midwives in maternity centers around the country.

FENOE, funded by POPPHI, wants to support MOH request by conducting a 3 day- training with QAP and School of Nursing trainers, in order to reinforce and standardize a team of trainers (midwives and doctors) in attending births using AMSTL.

PURPOSE

1. Review plans of action from three midwifery associations that attended the ICM Trinidad workshop.
2. Meet in each country with midwifery leaders to:
    - Review its plans of action;
    - Conduct an assessment of the use of active management of the third stage of labor (AMTSL) and the barriers to its use;
    - Assist each midwifery association to develop a proposal in each country (not to exceed $8,000 -10,000 per country).

BACKGROUND:

POPPHI project, ICM and JHPIEGO/Baltimore conducted a conference in Trinidad to promote the use of AMSTL in 2002. Participants were nurses and midwives for Latin-American countries who belong to Nurses/Midwives Association in their countries. Based on WHO international recommendations to decrease maternal and neonatal mortality, AMSTL and neonatal resuscitation skills were promoted and demonstrated during the conference, in addition to discussions about how to support the implementation of those skills in countries. Each country participant developed an action plan. El Salvador, Ecuador and Bolivia's participants reported advances implementing the use of AMSTL. Between January and April 2006, the three country's midwives and midwifery associations were visited to asses what had been done, and identify follow-up activities to support the use of AMSTL in the country

FINDINGS

1. AMSTL has not been properly implemented despite the fact that the procedure is included in the EOC training that QAP project has been giving in target areas in the country. The use of oxytocin is promoted during the third stage, but not the three steps of AMSTL.
2. The use of AMSTL still has many detractors of the evidence and/or international recommendations (doctors) who refuse to change.
3. Supplies are not an issue there at this time, as oxytocin is already included in the delivery package that is free for women
4. QAP is the bilateral project that is supporting the MOH to improve maternal and neonatal health by conducting 5 day-EOC courses.
5. Midwives and doctors who attended the Lima and Trinidad conferences did not feel confident in using AMSTL after the conference because of lack of practice with real clients under supervision, and because AMSTL was not then included in the national protocols.
6. MOH just made (April 18) an amendment to include AMSTL in the National Reproductive Health Norms as a result of QAP project, and MOH participants to the Trinidad Conference and FENOE strongly advocate TA support to develop the protocol. However, the use of AMSTL continues to be resisted from doctors, some of them within the MOH. The resistance is because AMSTL is associated with complications like retention of placenta and inversion of uterus. Nevertheless, none of the resistant doctors have received any training about how to correctly perform AMSTL.
7. Midwives do attend births mostly in maternities, in rural areas, and when residents and students are not available. Midwives are the most stable staff in the birthing rooms at the bigger hospitals while residents and students are constantly rotating through. However, the amount of midwives per shift is insufficient. Doctors and midwives work only 4 hrs per shift, and during evenings and nights there is only one midwife responsible for all the residents and students.
8. Training in-service and preservice do not include proper practice with real clients in order to assure skills competency.

9. MOH asked for TA from the QAP project to train midwives and doctors to implement AMSTL countrywide in the next couples of months. QAP expects to receive USAID fund in a couple of weeks to support MOH with this trainings. QAP has included AMSTL in the EOC courses, however, it needs to develop competency-based practice activities.
10. The school of Nursing of Quito will sign and agreement with QAP project in order for their faculty to receive the 5-day EOC training including AMSTL
11. The MOH expressed to FENOE that the role of midwives is vital to improve the quality of care and decrease MM, and it is available to give them a strong support to improve their skills by training, as well as to increase positions for midwives in maternities around the country

CONCLUSIONS

1. The MOH supports the use of AMSTL.
2. The MOH needs financial and technical support to train midwives and doctors who attend births in how to performance AMSTL
3. The QAP project is available to develop and standardize training in attendance of births using AMSTL including practice along with FENOE, and with POPPHI technical and financial support.
4. FENOE new goal is to reinforce midwives' skills for attending births using AMSTL by conducting competency-based trainings.
5. A team of trainers from FENOE, QAP project and School of Nursing will be standardized in how to attend births using AMSTL in order for them to support the MOH for training midwives and doctors to implement t AMSTL all over the country.
6. The 2 midwives and the 2 doctors who attended the Trinidad and Lima Conference will identify and prepare the clinical site for practice

RECOMMENDATIONS

1. Standardize a national team of trainers in skills to attend births using AMSTL. The team needs to be comprised of FENOE, QAP project, and school of nursing trainers as they are currently training health providers..
2. Skills standardization training needs to be competency-based and include practice with real clients.
3. To support the MOH in improving the 5-day EOC training and to assure nurses and doctors competencies using AMSTL with a standard or policy of care
4. Doctors needs to be trained *together with* nurses in order to practice WHO recommended practices for normal birth, including how to prevent episiotomy, receive and give immediate care to the baby, practice the three steps of AMSTL, and monitor the post partum period.
5. Identify if logistic support for the MOH is needed to assure sufficient amounts of oxytocin/syringes/needles at maternity centers, to assure practice of AMSTL.
6. The participants and this consultant consider that a 3-day training would be sufficient to gain competency, assuming that participants will be available to attend births during two

days within the training, even during the evenings if needed. If this is not possible, I suggest planning a 4-day training event.

TRIP REPORT

Gloria Metcalfe, MNH –LAC/C Consultant

Jan 30- Feb 02, 2006

Trinidad Conference follow- up visits

EL SALVADOR

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Abbreviations

POPPHI:	Prevention of post partum hemorrhage initiative
AMTSL:	Active Management of third stage of labor (MATEP in Spanish)
LAC/C:	Latin America and Caribbean
MNH:	Maternal and Neonatal health
MM:	Maternal Mortality
MOH:	Ministry of Health
EOC:	Essential Obstetric Care

EXECUTIVE SUMMARY

POPPHI consultant visited El Salvador to meet with midwife participant to the Trinidad Conference in 2002, for reviewing the status of the AMSLT implementation in the country according her Action plan. The MOH has included the AMSTL procedure in the National guidelines and the EOC trainings that MOH is conducting in order to decrease the MM mortality. At the time of the visit the MOH was conducting a survey for knowing about AMSTL use after the training. According to preliminary results, AMSTL is not implemented in all the facilities. Lack of oxytocin was mentioned, use of 5 IU of oxytocin instead of 10 IU, and doctor's resistance to change. Final results of the questionnaires will be sent by Nurse Celia Hernandez

The school of Nursing has also included AMSTL in the pre service curriculum. However practice with real clients is poor in both, trainings in service and pre service. Nurses do not regularly attend births. Their role is focused in giving support to doctors, residents and students when they are attending births, and particularly nurses are responsible for giving women oxytocin for AMSTL. The model for attending births is medicalized, i.e. only doctors

(or residents or students) are responsible of women in labor and they are attended by many persons. Lack of staff of nurses was mentioned, however, nurse's task during attendance of births is not registered and therefore there are not reasons to hire nurse and positions for nurses are decreasing. However nurses do attend births and must supervise residents and students when doctors are not available, mainly during night shifts and in rural areas. Therefore, nurses need to be properly trained by including a competency- based methodology in the pre service and in service curriculum. MNH unit from MOH, clinicians, nurses and doctors from hospitals, and School of Nursing are available to change the model to attend births, develop a Training Center and reinforce a national team of trainers in competence-based methodology in order to support the EOC trainings which include attendance of births using AMSTL.

PURPOSE

1. Review plans of action from three midwifery associations that attended the ICM Trinidad workshop.
2. Meet in each country with midwifery leaders to:
   - Review its plans of action;
   - Conduct an assessment of the use of active management of the third stage of labor (AMTSL) and the barriers to its use;
   - Assist each midwifery association to develop a proposal in each country (not to exceed $8,000 -10,000 per country).

BACKGROUND:

POPPHI project, ICM and JHPIEGO/Baltimore conducted a conference in Trinidad to promote the use of AMSTL in 2002. Participants were nurses and midwives for Latin-American countries who belong to Nurses/midwives Association in their countries. Based on WHO international recommendations to decrease maternal and neonatal mortality, AMSTL and neonatal resuscitation skills were promoted and demonstrate during the conference, in addition to discussions about how to support the implementation of those skills in countries. Each country participants developed an action plan. El Salvador, Ecuador and Bolivia's participants reported advances implementing the use of AMSTL. Between January and April 2006, the three country's midwives and midwifery association were visited to asses what has been done, and identify follow-on activities to support the use of AMSTL in the country

FINDINGS

1. Nurse Celia Hernandez from the El Salvador MOH Maternal and Neonatal Health Unit attended the Conference in Trinidad. She is currently in the same position. After Trinidad, Nurse Hernandez included AMSTL in the content of the regular EOC training that the MOH has been conducting since 2002.
2. The MOH is in the process of updating the Maternal and Neonatal Health National Norms, and AMSTL is included.
3. The MOH goal is to implement EOC in the 28 maternity centers around the country. As a result of an assessment in maternal and neonatal care, the MOH findings showed

lack of competency in clinical skills, equipment and supplies. The MOH is developing a variety of strategies in order to decrease MM and improve the quality of care. They are conducting a 3 day- training in EOC for doctors and nurses from these maternity centers. The training is focused on management of main maternal and neonatal complications, including attendance births using AMSTL. The training is basically theoretical, and the practice of skills on anatomic models is poor and does not assure competency on trainees. Trainees do not have supervised practice with real clients. After receiving the training, trainees have to replicate the training to the staff in their respective facilities. About 34% of providers have been trained to date.

4. The MOH was conducting a follow up of the training by asking staff in the facilities about the status of the implementation of AMSTL using a redesigned questionnaire. Questions are: When were you trained in the use of oxytocin?, Did you replicate the training?, Do you think that AMSTL is useful to prevent PPH? Are supplies sufficient? Is AMSTL implemented? In all births? Have you had troubles implementing AMSTL? Have you had some complications using AMSTL? Where do you register use of AMSTL? According to preliminary results, AMSTL is not implemented in all the facilities. Lack of oxytocin was mentioned, use of 5 IU of oxytocin, and doctor's resistance to change. Final results of the questionnaires will be sent by Nurse Celia Hernandez.
5. The Nursing school has included in the preservice curriculum a 14-week competencies course for obstetric nurses, where attending births using AMSTL is included. However, nurses do not regularly attend births though they officially can do it. This situation is due to a lack of nursing staff, intervention from medical students, residents and doctors who have priority use of the clinical sites, and clearly doctors feel they are responsible for attending women during birth. Nurses have an "auxiliary of doctors" role. In terms of AMSTL, Nurses only give the shot of oxytocin and they do not even understand that AMSTL is a three step procedure.
6. Nurses want to be responsible for attending women during birth, but they are not confident in doing it. However, nurses have to attend women when doctors are not available, during night shits, or in a rural areas. Nurses also have to supervise students when doctors are not present.
7. During the visit to a hospital in Sonsonate, the clinical team including the chief of the labor room acknowledged that the model they have for attending births are medicalized, even when doctors are busy attending other patients, and they just catch the baby or only repair the episiotomy or remove the placenta after the nurse administers the oxytocin. While nurses circulate around the doctor's needs, they cannot be unconcerned about women's needs. The nurse chief of the labor room recognized that they have not included international recommendations for supporting women during labor, and that the role of nurses is under-utilized. Due the amount of births in this hospital, the team was open to changing the model. Nurses showed interest in having a more professional role by receiving better training. This hospital was proposed to be the clinical site to conduct the practice for the training that POPHHI will support.(see proposal annex xx).
8. Doctors of Sonsonate hospital said that they use AMSTL and there is not lack of oxytocin, however, nurses do not do it and they were not sure if doctors really use the

three steps of the procedure. Sometimes they use only 5UI of oxytocin, as that was the doses recommended by the protocols (which were updated).

9. The EOC trainings conducted by the MOH have not been continued in a regular way due to lack of funds. The MOH is waiting for the USAID/El Salvador Mission decision about the next bilateral that will follow the SALSA project activities regarding Maternal and Neonatal Health. According to the USAID/ES, the new bilateral project will start in March 06.
10. USAID/ES agreed to the recommendation and proposal of activities that I presented about this visit (see below).

CONCLUSIONS

1. The MOH supports the use of AMSTL.
2. Nurses do not feel competent to attend births. Attending births is legally part of the nurses' professional role, and they occasionally do attend births as well as supervise students in practice.
3. Doctors attend births at the expulsion stage and count on the nurse to administer oxytocin.
4. All recognized the importance of practical skills training for AMSTL.

RECOMMENDATIONS

1. Identify if logistic support for the MOH is needed to assure sufficient amounts of oxytocin/syringes/needles at maternity centers, to assure practice of AMSTL.
2. To support the MOH in improving EOC training and assuring nurses' and doctors' competencies using AMSTL with a standard or policy of care.
3. Nurses must be properly trained with skills practice, based on competency-based training methodology.
4. Doctors needs to be trained together with nurses in order to practice WHO recommended practices for normal birth, including how to prevent episiotomy, receive and give immediate care to the baby, practice the three steps of AMSTL, and monitor the post partum period.
5. Training needs to emphasize the practice and standardization of AMSTL skills.
6. The participants and this consultant consider that a 3-day training would be sufficient to gain competency, assuming that participants will be available to attend births during two days within the training, even during the evenings if needed. If this is not possible, I suggest planning a 4-day training event.

Appendix B: Mali Trip Reports

TRIP REPORT

Travellers: Susheela Engelbrecht, CNM, MPH, MSN

Country Visited: Mali

Dates of Trip: May 15-19, 2006

Purpose of Trip: Start-up visit:

1. Meet ATN project director (bilateral project), Ciro Franco, Cheick Touré, IntraHealth/Capacity, and Christine Sow, USAID.
2. Have MOU signed and collect a copy of signed document.
3. Discuss and finalize use of oxytocin in Uniject with team, USAID and MOH.
4. Review job description and roles/responsibilities for Malian midwife candidate.
5. Interview and hire a Malian midwife.
6. Set up mechanism for money transfer and management, including bank account.
7. Develop a work plan and review/revise the basic outline for the *matrone* training.
8. Visit a site for the *matrone* training, if possible.

EXECUTIVE SUMMARY

From May 15-19, 2006, Ms. Susheela Engelbrecht, Midwifery consultant, traveled to Mali to work with POPPHI partners, IntraHealth/Capacity, ATN, Care International/Kineya Ciwara (KC), and the MOH to finalize plans for the pilot demonstration project. Ms. Engelbrecht met with key partners, developed a training strategy, finalized a list of indicators and tools for baseline data collection, finalized the project proposal and work plan, developed a provisory time line, and discussed finalizing the MOU and plans to hire a Malian midwife.

ACCOMPLISHMENTS

1. Ms. Susheela Engelbrecht met with Dr. Cheick Touré, IntraHealth/Capacity, Dr. Ciro Franco, Dr. Arkia Doucouré, and Ms. Laura Hurley, ATN, to discuss details of Ms. Engelbrecht's visit, to review key points of the project proposal, and discuss the MOU.
2. Susheela Engelbrecht and Dr. Touré met with Dr. Sangaré Madina Bâ and Dr. Kwamy Togbey, Care International/KC, to review key points of the project proposal and discuss the MOU.

3. Susheela Engelbrecht, Dr. Touré, and Dr. Franco met with Dr. Binta Diagne, Director of the DSR, to discuss details of the project, get provisory permission to use Uniject, discuss site choices and possible site selection criteria, and talk over major concerns the MOH has about training *matrones* in the practice of AMSTL.

4. Susheela Engelbrecht and Dr. Touré met with members of the technical group (please see the list of persons contacted) to review the training strategy, key details of the project proposal, choice of "circles" for the project, key concerns about training *matrones*, and agree on a tentative timeline.

5. Susheela Engelbrecht, Dr. Touré, Dr. Franco, and Ms. Hurley met with USAID representatives, Ms. Christine Sow and Mr. Sixte Zigirumugabé, to provide a debriefing on Ms. Engelbrecht's visit, and to discuss the project proposal, the proposed training strategy, use of Uniject in the pilot demonstration project, details of the MOU, and selection of sites for the project.

6. Ms. Susheela Engelbrecht and Dr. Cheick Touré discussed and finalized indicators and data collection tools with Dr. Arkia Doucouré and Ms. Laura Hurley.

7. Small changes in the MOU were requested by Care International/KC and agreed to in principle by the PATH consultant, IntraHealth/Capacity, and ATN. Dr. Ciro Franco of ATN has concerns about the availability of a vehicle and has postponed signing the MOU until USAID has provided information about the possible allocation of an additional vehicle to ATN. Once all partners in Mali have agreed upon the terms of the MOU, it will be sent to PATH DC for final approval and signing.

8. The training strategy was agreed upon, the project proposal and work plan were rewritten to reflect the newly designed training strategy, indicators were agreed upon and data collection tools were adapted to reflect indicators, details of the MOU were agreed upon, negotiations were initiated to hire a Malian midwife through IntraHealth/Capacity, and agreement was reached to use Uniject in 2 of the 4 demonstration "cercles."

9. Due to time constraints no sites were visited by the consultant. Ms. Engelbrecht, however, has a long history of working in Mali as a nurse-midwife and was part of the team that introduced AMSTL into Mali in 2001.

10. Decisions about hiring the Malian midwife and setting up a mechanism for money transfer and management were made through discussions between IntraHealth/Capacity in Mali and Chapel Hill and the Path DC office.

FINDINGS/CONCLUSIONS AND RECOMMENDATIONS

1. The project proposal was revised to choose CSCOMs rather than individual matrones

Given the safety concerns about matrones being trained in the practice of AMSTL and being allowed to use oxytocin, a decision was reached to train matrones in selected CSCOMS in 4 "cercles," and to ensure adequate support for them by training all personnel conducting births in the practice of AMSTL in all regional hospitals and CSREFs in the "cercle."

Recommendations

- Work with authorities to choose selection criteria for CSCOMs.
- Work with authorities at the "cercle" level to choose 5 CSCOMs per "cercle" from which matrones will be trained.
- Use the National Training Pool and existing training materials to train midwives, obstetrical nurses, and doctors conducting births at the regional hospital and CSREF level.
- The budget will need to be revised to reflect training activities planned for midwives, obstetrical nurses, and doctors conducting births at the regional hospital and CSREF level.

2. The training strategy was revised to include training In-charges working in CSCOMs where matrones are working

In-charges at the CSCOMs usually do not conduct births but are responsible for providing daily supervision and medical back-up for matrones working at their sites. These in-charges will need to be oriented to the practice of AMSTL in order to support the matrones in the mastery of this new skill. In addition, they will need to know how to respond in the unlikely event that there is a complication due to AMSTL at the CSCOM.

Recommendations

- Once midwives, obstetrical nurses, and doctors conducting births at the regional hospital and CSREF level have been trained in AMSTL, in-charges will be provided an orientation to AMSTL and will be trained to respond to the most common complications of AMSTL.
- Training materials will be adapted for the in-charges.
- The budget will need to be revised to reflect training activities planned for In-charges at the CSCOM level.

3. All sites in the demonstration pilot project will need regular supplies of oxytocin that are being stored according to manufacturers' recommendations

If the practice of AMSTL by matrones is to be properly evaluated, they will need to have regular supplies of oxytocin that have not lost its potency. In order to ensure this, pharmacists and pharmacy managers at selected sites will be trained in use, ordering, and correct storage of oxytocics.

Uniject has many advantages over the traditional ampoules of oxytocin, but has not yet been put on the national formulary. The MOH has no direct concerns about using Uniject, but requests that the project go through the regulated process of getting a drug accepted for use in Mali. Ms. Christine Sow, USAID, expressed a concern that the possibility for scale-up may be hindered if only Uniject is used for the pilot project.

Recommendations

- Pharmacists and pharmacy managers will be trained by the National Pool of Trainers using training materials that have already been developed for Mali.
- Dr. Touré and PATH technical advisors will need to work with the DPM to get approval for use of Uniject in the pilot demonstration project.
- Uniject will be used in two "cercles" and the traditional ampoules of oxytocin will be used in the other two "cercles" to avoid success and/or failure of the demonstration to be attributed to the use of Uniject.

4. Matrones in 4 "cercles" will trained in the practice of AMSTL

Two to four midwives/obstetrical nurses from each "cercle" will be chosen by the national pool of trainers and "cercle" authorities to serve as trainers for the matrones in the practice of AMSTL. Training of these trainers will address the concerns of the national pool of trainers that midwives and obstetrical nurses selected from the "cercle" level to train matrones may not have adequate training in teaching or supervising them.

Training topics for matrones will address the most important concerns about training matrones in the practice of AMSTL:

i. Matrones have been known to inappropriately use oxytocin in the antepartum or intrapartum periods with associated risks, including ruptured uterus;

ii. Some providers fear that matrones may incorrectly apply AMSTL and incur the possible complications of postpartum hemorrhage, retained placenta, and inverted uterus.

The National Pool of Trainers (NPT) noted that matrones "should" be literate but recommended that training materials be set at about a 6^{th} grade level. Also, some concern was expressed about current labor and childbirth practices by many matrones, and the NPT felt that they needed an update in or "reminder" of the principles of conducting a clean and safe childbirth.

Recommendations

- Develop training materials for TOT of trainers who will be responsible for training matrones in the practice of AMSTL that include information on teaching and supervising matrones.
- Develop training materials for matrones that are at a 6^{th} grade level of reading and comprehension and include a refresher about clean and safe childbirth and information on the dangers of abusing oxytocin.

- Order at least one obstetric mannequin per "cercle" for training activities at all levels in the "cercle."

5. Baseline data will need to be collected in selected sites

Indicators and data collection tools were revised for the pilot project to reflect concerns voiced by the MOH. The goal of the pilot project is not to demonstrate the safety/efficacy of AMSTL but rather to demonstrate the safety and feasibility of training matrones in the practice of AMSTL.

Recommendations

- Use data collection teams trained for data collection for the initial PPPH project in Mali.
- Begin baseline data collection as soon as possible after sites have been selected.

LIST OF APPENDICES

Appendix A: List of Abbreviations

AMSTL	Active management of the third stage of labor
ATN	Assistance Technique Nationale
CSCOM	Community Health Centre
CSREF	Reference Health Centre
DNS	Direction Nationale de la Santé
DSR	Division Santé de la Reproduction
DPM	Direction for Pharmacy and Medications
KC	Keneya Ciwara
MOU	Memorandum of understanding
MOH	Ministry of Health
NPT	National Pool of Trainers
TOT	Training of Trainers

Appendix B: Assignment Description

Scope of Work: POPPHI Project

Name: Susheela Engelbrecht
Dates: May 3–December 31, 2006
Number of Days: up to 50 days
Location: Washington, DC; Seattle, WA; Mali

Purpose: To assist in development and provide overall coordination for work done in Mali by POPPHI, collaborating closely with POPPHI staff.

Activities:

1. Review all materials provided and attend orientation at PATH in early May 2006.
2. Serve as POPPHI's technical coordinator for the Mali: Matrones and oxytocin project.
3. Make up to 4 visits to Mali:

A. Start-up visit:

- Meet ATN project director (bilateral project), Ciro Franco, Chieck Toure, IntraHealth/Capacity, and Christine Sow, USAID.
- Have MOU signed and collect a copy of signed document.
- Discuss and finalize use of oxytocin in Uniject with team, USAID and MOH.
- Review job description and roles/responsibilities for Malian midwife candidate.
- Interview and hire Malian midwife.
- Set up mechanism for money transfer and management, including bank account.
- Develop a workplan and review/revise the basic outline for the matrone training.
- Visit a site for the matrone training, if possible.

B. Training visit:

Prior to visit:

- Work with Mali staff midwife and coordinate with C. Toure to finalize the training plan.
- Ensure adequate funding in Mali bank and other logistics arranged.

During visit:

- Assist with training of trainers and take primary responsibility for Uniject training component.
- Assist and provide supervision for the new trainers' first training of matrones.
- Finalize supervision plan for visits to matrones after training.

C. Supervision visit:

- Visit selected number of matrones and their supervisors at all four sites (or one site in north and one in south).
- Hold discussions, provide guidance, and make recommendations for any changes that are needed/required.

- Meet with ATN COP, C. Toure, USAID, and MOH representatives to discuss progress on pilot project.

D. Data analysis and dissemination workshop:
Prior to visit:
- Assist in reviewing data available; identify problems and assist in creating solutions.
- Assist or provide oversight to planning for dissemination workshop.

During visit:
- Assist with dissemination workshop.
- Hold discussions with MOH, USAID, and other important stakeholders on results and potential follow-on work.
- Collect all documents in electronic and hard copy.
- Discuss next steps: expansion, writing reports and articles for peer-reviewed journals.

4. Finalize reports and articles for peer-reviewed journals.

Deliverables:

1. A trip report (in English) for each trip to Mali, sent electronically (and any appendices that are hard copy will be sent via post) within 2 weeks of trip and following the designated format.
2. Copies of all training material, in hard copy and electronically, are provided to POPPHI.
3. Final report (in English) of Matrones and oxytocin project.
4. Assist with peer reviewed article on the results of the pilot project.
5. All primary documents (determined in collaboration with POPPHI staff) will be provided in English. The use of a translator is possible if negotiated with POPPHI staff.

Appendix C: Persons Contacted/Met

USAID	
Dr. Christine SOW	Chef d'équipe Santé
M. Sixte Zigirumugabé	Conseiller technique
IntraHealth International Mali	
Dr. Cheick Oumar Touré*	Country Director
Assistance Technique Nationale	
Dr. Ciro Franco	Chief of Party
Dr. Arkia Doucouré*	Conseillère SR/PF
Ms. Laura Hurley*	Michigan Fellow
Keneya Ciwara	
Dr. Kwamy Togbey	Chief of Party
Dr. Sangaré Madina BA*	Conseillère SR/PF
Mme. Touré Aminata Dagnoko*	Conseillère Formation Clinique
Mme. Konaté Ramatou Fomba*	Chargée de Formation Clinique
Division Santé de la Reproduction	
Dr. Binta Keita	Chef de Division
Mme. Haoua Diallo*	Chargé de Santé Maternelle
Mme. Oumou Keita *	Chargé de Genre
Association des sages femmes	
Mme. Dicko Fatoumata*	Présidente

*All of these people were present at the meeting with the technical group.

Appendix D: Project Time Line

Calendar of Activities
Prevention of Postpartum Hemorrhage: Mali

ACTIVITES	Trimester 2 – 2006			Trimester 3 – 2006			Trimester 4 – 2006			Trimester 1 – 2007			Trimester 2 – 2007			Trimester 3 – 2007			Trimester 4 – 2007		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
1. Create a Technical Advisory Committee																					
2. Finalize the pilot study protocol																					
3. Develop training strategy, materials and schedule of activities (in workshop)																					
4. Prepare the tools for collecting data and providing support/supervision at the sites																					
5. Collect baseline data																					
6. Conduct a workshop to present baseline data																					
7. Adapt existing learning materials for training *matrones*																					
8. Train all skilled birth attendants (midwives, doctors) at selected CSREFs																					
9. Train In-Charges of selected CSCOMs																					

ACTIVITES	Trimester 2 – 2006			Trimester 3 – 2006			Trimester 4 – 2006			Trimester 1 – 2007			Trimester 2 – 2007			Trimester 3 – 2007			Trimester 4 – 2007		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
10. Train trainers of matrones[3]																					
11. Train matrones																					
12. Train pharmacists and pharmacy managers																					
13. Provide ongoing supervision and monitoring																					
14. Perform an interim evaluation of trained matrones (6 months after the initial training)																					
15. Conduct the final evaluation																					
16. Disseminate results and lobby for expanded scope of practice for matrones that includes AMSTL																					

[3] The TOT for trainers of *matrones* will be scheduled for August 21-25, 2006; All newly trained trainers will then conduct an initial training for *matrones* August 28-September 1, 2006 – master trainers will observe and provide TA during this initial training for *matrones*

Appendix E: Deliverables

i. Project proposal – English and French
ii. Training strategy – English and French
iii. POPPHI results framework – English
iv. Analysis Plan (list of indicators) – English and French
v. Facility Audit – French
vi. Record Review – French
vii. Provider Interview – French
viii. AMSTL Checklist - French

Appendix C: POPPHI Job Aids Distribution List

Name	Organization	English factsheet	English poster	French factsheet	French poster	Spanish factsheet	Spanish poster	Country
Entebbe Conference		1000	1000		300			Angola, Burkina Faso, DRC, Ethiopia, Ghana, Malawi, Mali, Mozambique, Nigeria, Tanzania, Zambia, Togo, South Africa, Kenya, Uganda, Benin, Mauritania, Madagascar, Haiti
Global Health Council		25	25		25			global
P.K. Shah	FOGSI	350	350					India
Goa/New Delhi meetings		350	350					India-Asia
retreat members	Save the Children	15	15					global
India meetings	various	200	200					Asia region
TOTALS		1940	1940		325			

Appendix D: PPH Toolkit Distribution List (February 1–July 31, 2006)

Date	Requested by	Organization	Sent to	Organization	No. of condensed	No. of reference/ library	No. of CD ROMS	Country/ countries
4/24/2006	CORE Group Meeting		D. Madrid	ADRA	1			Madagascar, Mozambique, Cambodia
4/24/2006	CORE Group Meeting		Melanie Swan	Plan	1			LAC
4/24/2006	CORE Group Meeting		Janine Schooley	PCI	1			global
4/24/2006	CORE Group Meeting		Leigh Wynne	GHA	1			Haiti, China, Africa
4/24/2006	CORE Group Meeting		Erin Mielke	EngenderHealth	1			global
4/24/2006	CORE Group Meeting		Guerda Debrosse	Concern	1			Haiti, China, Africa
4/24/2006	CORE Group Meeting		Diana DuBois	MIHV	1			Uganda, Tanzania
4/24/2006	CORE Group Meeting		Kavita Singh	MEASURE Evaluation	1			Africa
4/24/2006	CORE Group Meeting		Bonnie Kittle	Project HOPE	1			CAR, Nicaragua, Haiti, Mozambique
4/24/2006	CORE Group Meeting		Henry Perry	Future Generations	1			Peru
4/24/2006	CORE Group Meeting		E. Chung	USAID	1			
4/24/2006	CORE Group Meeting		Meg Galas	PSI	1			
4/24/2006	CORE Group Meeting		Lisa Bowen	Plan USA	1			
4/24/2006	CORE Group Meeting		Kali Erickson	Curamericas	1			Guatemala, Bolivia
4/24/2006	CORE Group Meeting		Issiaya Daffe	Africare	1			

Date	Requested by	Organization	Sent to	Organization	No. of condensed	No. of reference/ library	No. of CD ROMS	Country/ countries
4/24/2006	CORE Group Meeting		Core members		5			global
5/4/2006	POPPHI		Sushie Engelbrecht	consultant		1	1	Mali
5/28/2006	POPPHI		participants	Global Health Council	20			
6/7/2006	Save the Children	Save the Children	retreat participants	Save the Children	20			
7/31/2006	Diana Beck	ACNM	Pakistan ob/gyns/midwives	Pakistan professional associations		15	15	Pakistan
3/1/2006	Meghan Greeley	PATH	PPH conference, Uganda	ACCESS-funded conference	150	0	150	Uganda
6/12/2006	Meghan Greeley	PATH	July mtg in Goa, India		200	5	60	India
6/12/2006	Meghan Greeley	PATH	July MotherNewBorNet mtg in India		100	5	60	India
		PATH	WRA National Secretariat in India		45	10	35	India
				TOTALS	**555**	**36**	**321**	

Appendix E: FIGO Tracking Database

See attached Excel Spreadsheet.

POPPHI: Tracking the distribution and awareness of the Joint Satement

PPH Survey	Are aware	Country	Region	*	Contact Person	Email	Affiliation	Disseminated to	Other activities conducted
Yes	Yes	Argentina	South Amer	M	Dr. Jorge Gori, Galimberti Diane, Dr Carlos Rafael Ortega Soler	dianagalimberti@yahoo.com; fasgo@abaconet.com.ar	FIGO		Presentations at national and district meetings
Yes	Yes	Bangledesh	Asia	L	Prof. Abdul Bayes Bhuiyan; Professor Anowara Begum	ogsb@agni.com	FIGO	to member list private and public hospitals and health units	Presentations at national and district meetings
Yes	Yes	Benin	Africa	L	Prof José de Souza, Dr Antoine Lokossou	alihonou@intnet.bj; Amoussouceline@yahoo.fr; cerrhud@intnet.bj	FIGO	to the ministry of health, the member list, public hospitals and pharmacies	Presentations at national meetings
Incomplete	Yes	Bolivia	South Amer	M	Luis Zarate Pereira, Emiliana Pallarec Camargo	emilianapallores@hotmail.com; isare@cotas.com.bo; sbog@cotas.com.bo	FIGO		
Yes	Yes	Brazil	South Amer	M	Dr. Geraldez Tomaz, Jacob Arkador, Edmund Chada B, Sérgio Martins-Costa	febrasgopresiden@uol.com.br; scosta@hcpa.ufrgs.br; presidencia@febrasgo.org.br	FIGO	to member list, the Ministry of Health	Conducted presentations at national meetings
Yes	Yes	Bulgaria	Europe	M	Dimitar Georgiev, Professor Elian Ratchev	georgiev@spnet.net; elianratchev@hotmail.com	FIGO		
Yes	Yes	Burkina-Faso	Africa	L	Prof Jean Lankouande	cliniqueyentema@hotmail.com	FIGO	to member list, MOH, public and private hospitals	Presentations at district meetings
Yes	Yes	Cameroun	Africa	L	Porf. Robert Leke, Dr. Leice Robert	robert.leke@camnet.cm	FIGO	to member list and public hospitals	Presentations at national meetings
yes	Yes	Canada	North Amer	H	Dr. Andre Lalonde	alalonde@sogc.com	FIGO	to member list, MOH, hospitals	Presentations at national meetings
No	Yes	Centrafrique	Africa	L	Dr. Abdoulaye Sepou	sepou_abdoulaye@yahoo.fr	FIGO		
Yes	Yes	Chile	South Amer	M	Enrique Oyarzun, Eugenio Suarez Pacheco	eoyarzun@med.puc.cl	FIGO		
Yes	Yes	Colombia	South Amer	M	Dr. Jose William Leon	scog@interred.net.co; sochog@entelchile.net	FIGO		
Yes	Yes	Costa Rica	Cent. Amer	M	Carlos Castro Echeverri, Dr Kay-Uwe Sander	ccastroe@racsa.co.cr; ksander@cariari.ucr.ac.cr	FIGO		
No	Yes	Cote-d'Ivoire	Africa	L	Prof Simplice Anongba	cwelffens@yahoo.com	FIGO		
Yes	Yes	Cuba	Cent. Amer	M	Dr. Blanca Manzano, Evelio Cabezas, Dr Manuel Veranes Arias	cnsc@infomed.sld.cu, ecabezas@infomed.sld.eu	FIGO	the ministry of health	
yes	Yes	Denmark	Europe	H	Dr. Jeffrey Lazarus; Dr. Vibeke Rasch, Lone Hvidman	jeffrey.lazarus@smi.mas.lou.se; vrasch@dadlnet.dk; lone.hvidman@dadlnet.dk	FIGO		
Yes	Yes	Dominican Republic	Cent. Amer	M	Milton Codrdero or Figueroa	tmcordero@verizon.net.do	FIGO	our member list, MOH, public and private hospitals	Presentations at national and regional meetings and other
Yes	Yes	Ecuador	South Amer	M	Andres Calle, Dr. Arosei Gaue	fesgo2006@yahoo.es; qualle@uio.satnet.net	FIGO		Conducted presentations at national meetings
Yes	Yes	El Salvador	Cent. Amer	M	Mercedes Haytee Abrego de Aguitar	mercedes53@telesol.net; asogoes@hotmail.com	FIGO		Conducted presentations at national meetings
Yes	Yes	Ethiopia	Africa	L	Dr. Zerai Kassaye, Dr. Ashebir Getachew, Solomon Kumbi Hawas;	zeraikassaye@yahoo.com, asshebirg@telecom.et; esog@telecom.net.et	FIGO	to our member list, the ministry of health	Presentations at national and regional meetings

POPPHI: Tracking the distribution and awareness of the Joint Satement

PPH Survey	Are aware	Country	Region	*	Contact Person	Email	Affiliation	Disseminated to	Other activities conducted
Yes	Yes	Finland	Europe	H	Risto Tuimala; Professor Seppo Heinonen	risto.tuimala@pshp.fi; seppo.heinonen@kuh.fi	FIGO		Presentations at meetings of our global region
No	Yes	Gabon	Africa	M	Prof. Toussaint Engongah	meye.jf@voila.fr	FIGO		
Yes	Yes	Georgia	Europe	L	Tengiz Asatiani;	tengiz.asatiani@caucasus.net	FIGO	to the MOH and private hospitals	Presentations at national meetings
Yes	Yes	Greece	Europe	H	Professor George Creatsas	geocre@aretaieio.uoa.gr; helobgyn@otenet.gr	FIGO		
Yes	Yes	Guatemala	Cent. Amer	M	Hector Romeo Menendez	hearomear01@yahoo.com	FIGO	to member list, public hospitals, nursing stations	Conducted presentations at district meetings
No	Yes	Guinée	Africa	L	Prof. Namory Keita; Professor M.D. Balde	bindiallo223@hotmail.com	FIGO		
Yes	Yes	Haiti	Cent. Amer	L	Dr. Reynold Grand Pierre; Dr. Lauré Adrien	shog@hainet.net; ladrien@hainet.net	FIGO		
Yes	Yes	Honduras	Cent. Amer	M	Jesus Vallecillo	jvallecillo@hmc.hn; sgineh@hotmail.com	FIGO	to member, public and private hospitals and health units, ministry of health	Presentations at national, district and meetings of our global region
Yes	Yes	Hong Kong	Asia	H	Dr. LAM SIU KEUNG; Dr Dominic Li	lamsk@ha.org.hk; dfhli@hkstar.com	FIGO		
Yes	Yes	Iceland			Reynir Tomas Geirsson; Dr Osk Ingvarsdottir	reynirg@landspitali.is	FIGO	to our member list	other
Yes	Yes	Iraq	Middle East	M	Noufal Azzuo	fawzi_azzo@yahoo.com	FIGO		
Yes	Yes	Ireland	Europe	H	Prof Fergal Malone, Dr John Gallagher	fmalone@rcsi.ie	FIGO	to our member list	other
Yes	Yes	Japan	Asia	H	Professor Shingo Fujii	sfu@kuhp.kyoto-u.acijp; nissanfu@jsog.or.jp	FIGO		
No	Yes	Jordan	Middle East	M	Dr. Ahmed abdel Wahed, Dr. Abdul Malek, Dr. Saeed Ziadeh, Dr A.M. Abdul Malek	ahmadd500@yahoo.com; malek_ama@yahoo.com; ziadeh@index.com	FIGO		
No	Yes	Kenya	Africa	L	Dr. Machoki, Dr. Jennifer Liku, Jean Kagia, Dr J G Karanja, Dr J G Karanja	mmachoki@africaonline.co.ke; kliku@fhi.or.ke; kagia@africaonline.co.ke; kogs@wananchi.com	FIGO		
no	Yes	Lebabanon	Middle East	M	Dr. Muhieddine Soeud, Professor Georges El-Kehdy	mike@aub.edu.lb; gkehdy@idm.net.lb	FIGO		
Yes	Yes	Macao SAR	Asia		Lei Ngan, 'Vong Kit Man	ogmacau@yahoo.com.hk	FIGO		
Yes	Yes	Macedonia (Republic of)	Europe	M	Dr. Slavejko Sapunov	dr_sapunov@yahoo.com	FIGO		
Incomplete	Yes	Malawi	Africa	L	Dr. Lewei Pearson	luwei@wnanchi.com	FIGO		
No	Yes	Mali	Africa	L	Dr. Fatimata Diakite, Mariam Diakité	mamoudiak@hotmail.com	FIGO		
No	Yes	Mauritanie	Africa	L	Dr. Raymond Najjar	majjar.r@voila.fr	FIGO		
Yes	Yes	Mexico	Cent. Amer	M	Dr Javier Santos González	femego@infosel.net.mx	FIGO		
no	Yes	Netherlands (The)	Europe	H	Dr. Christian Fiala; Dr. Jos van Roosmalen	christian.fiala@aon.at; j.j.m.van_roosmalen@lumc.nl	FIGO		presentations at district meetings
Yes	Yes	Nicaragua	Cent. Amer	L	Efrain Torouno Solis	socfenic@ibw.com.ni	FIGO		

POPPHI: Tracking the distribution and awareness of the Joint Satement

PPH Survey	Are aware	Country	Region	*	Contact Person	Email	Affiliation	Disseminated to	Other activities conducted
Incomplete	incomplete	Niger	Africa	L	Dr. Nafiou IDI	idinafi@refer.ne; idinafi@yahoo.fr; idinafi@refer.ne	FIGO		
yes	Yes	Nigeria	Africa	L	Prof. O. F. Giwa Osagie; Prof. F. Okonofua; Dr J. T. Akuse	giosagie@infoweb.abs.net; wharc@hyperia.com; jakuse@hotmail.com	FIGO		
Yes	Yes	Norway	Europe	H	Kjell Salvesen, Dr Oddvar Sviggum	pepes@ntnu.no; Oddvar.Sviggum@smr.no	FIGO		
Yes	incomplete	Pakistan	Middle East	L	DR.RAZIA KOREJO; Professor Farrukh Zaman	fzaman70@hotmail.com	FIGO		
Yes	Yes	Panama	Cent. Amer	M	Sara Campana, Rafael De Gracia, Dra. Magalli Moreno de Zevallos	scampano@psl.net.pa, jzevallo@sinfo.net, spogpana@bellsouth.net.pa	FIGO		
Yes	Yes	Paraguay	South Amer	M	Dr. Hugo Arellanos, Carlos Mongelos, Vicente Acuna, Hugo Cesar	digeprosalpy@yahoo.es; spgo@telesurf.com.py	FIGO	to the ministry of health	Presentations to national, district and meetings of our global region
Yes	Yes	Peru	South Amer	M	Eduardo Maradieue, Luis Tavara, Migual Gutierrez Ramos, Dr Rita Etcheverry	spot@terra.com.pe	FIGO	to our member list	
Yes	Yes	Poland	Europe	M	Professor Krzysztof Drews; Professor Marek Spaczynski	kdrews@am.poznan.pl; kdrews@gpsk.am.poznan.pl; ptgzg@gpsk.am.poznan.pl	FIGO		
no	Yes	Qatar	Middle East		Dr. Badr Eddine		FIGO		
no	Yes	Rep. Dem. Du Congo	Africa	L	Dr. Alois Nguma Mongaza	nguma-alois@yahoo.fr	FIGO		
no	Yes	Rep. Pop du Congo	Africa	L	Prof. Herve Iloky	herviloki@yahoo.fr	FIGO		
no	Yes	Saudi Arabia	Middle East	M	Dr. Hassan Ali Nour El-deen Nasrat, Dr. Afaf Tawfic, Dr Hassan S Jamal	hnasrat@hotmail.com; nehadt@hotmail.com	FIGO		
yes	Yes	Senegal	Africa	L	Dr. Rose Wardini	jrhachem@enda.sn; ceforep@sentoo.sn	FIGO		presentations of our global region
Incomplete	yes	South Africa	Africa	M	Dr. Palane Tlebere; Professor Gerhard Lindeque	tlebep@health.gov.za; glindequ@medic.up.ac.za	FIGO		
no	Yes	Sudan	Africa	L	Prof. Abdelsalam Gerais		FIGO		
Yes	Yes	Sweden	Europe	H	Charlotta Grunewald; Dr Margareta Hammarstrom	Charlotta.grunewald@sodersjukhuset.se	FIGO		
Yes	Yes	Switzerland	Europe	H	PD Dr. Irene Hösli, Prof. Dr. Wolfgang Holzgreve, Carolyn Troeger,	ihoesli@uhbs.ch; ctroeger@uhbs.ch; wolfgang.holzgreve@unibas.ch; wholzgreve@uhbs.ch	FIGO	to our member list	presentations at national meetings and other
yes	Yes	Taiwan	Asia		Hsin-Fu Chen, M.D.; Dr Maw Sheng Lee	hfchen@ha.mc.ntu.edu.tw	FIGO		
no	Yes	Tanzania	Africa	L	Dr.Mohammed Makwani; Dr. Tedesse Kitilla; Dr Ahmad Mohamed Makuwani; Professor Richard S.M. Lema	amakuwani@much.ac.tz; tkitilla@yahoo.com; gmbaruk@africaonline.co.tz; amakuwani@yahoo.com	FIGO		presentations at meetings of global region
no	Yes	Togo	Africa	L	Prof. Sénémé Baeta	sbaeta@tg.refer.org	FIGO		

POPPHI: Tracking the distribution and awareness of the Joint Satement

PPH Survey	Are aware	Country	Region	*	Contact Person	Email	Affiliation	Disseminated to	Other activities conducted
yes	Yes	Uganda	Africa	L	Dr. Pius Okong; Dr Jolly K Beyeza	aogu@africaonline.co.ug; pio_okong@yahoo.co.uk	FIGO	to our member list, and MOH	presentations at national meetings
yes	Yes	UK	Europe	H	Dr. Andrew Weeks; Richard Warren; Professor William Dunlop	aweeks@liverpool.ac.uk; rwarren@rcog.org.uk; president@rcog.org.uk	FIGO		
yes	Yes	Ukraine	Europe	L	Iryna Mogilevkina; Dr Boris Ventkovsky	Imogilevkin@excite.com	FIGO		
Yes	Yes	Uruguay	South Amer	M	Justo Alonso; Francisco Coppola; Dr Justo Alonso	sgubib@mednet.org.uy; Fracopp@adinet.com.uy; sgubib@chasque.apc.org	FIGO		
No	Yes	Venezuela	South Amer	M	Rafael Molina; Juan Antonio Yabur; Dr Leonor Zapata		FIGO		
no	Yes	Zimbabwe	Africa	L	Prof. Jonathan Kasule; Dr. Stephen Munjanja;	obsgynapari@zol.co.zw; spmunjanja@africaonline.co.zw	FIGO		
Yes	Yes	Afhanistan	Asia	L	Pashtoon - Azfar	pazfar@jhpiego.net	ICM	to the ministry of health	presentations at national meetings
Yes	Yes	Austria	Europe	H	Renate Grossaichlet-Ur-Lrig	oehg@hebammen.at, oehg@hebammen.at	ICM	yes, through their journal	
yes	Yes	Benin	Africa	L	Lawrence O Monteiro	saslolo@yahoo.fr	ICM	to our member list	presentation at meetings of our global region
No	No	Bosnia and Herzegowina	Europe	M			ICM	no	
yes	Yes	Burkina-Faso	Africa	L	Foro/Ouedrago Maimouna	foro12000@yahoo.fr, cpsf@fasonet.bf	ICM	to member list, MOH, public and private hospitals and clinics	presentations at district meetings
yes	Yes	Cameroun	Africa	L	Feugang	jrfeugang@yahoo.fr	ICM		
no	Yes	Canada	North Amer	H			ICM	yes	
yes	Yes	Chile	South Amer	M	Leticia Lorenzetti Silva	colegiomatronaschile@tie.cl	ICM	yes, through education programs and website	
yes	Yes	Croatia	Europe	M	Erika Spiric / Barbara Finderle	barbara.finderle@ri.htnet.hr; erika.spiric@vz.t.com; hrobv-biblioteka@vz.hinet.hr	ICM		presentations at national meetings
no	Yes	Cyprus	Middle East				ICM	yes, through educational programs	
yes	Yes	Czech Republic	Europe	M	Zuzana Stromerova	stromer@chello.cz; stromer@dkm.cz	ICM		
no	Yes	Denmark	Europe	H			ICM	yes, through their journal	
yes	Yes	Ethiopia, Africa	Africa	L	Kiros Kebede Gugesa	emma@telecom.net; ipaseth@telecom.net.et	ICM	to our member list and the ministry of health	presentations at national meetings
no	yes	Equador	South Amer	M			ICM	yes, through workshops	
no	yes	Germany	Europe	H			ICM	no	
yes	Yes	Ghana	Africa	L	Kathlyn Pemamte Perpetual	kathlynababio@yahoo.com;	ICM	yes	
Incomplete	Yes	Greece	Europe	H	Olga Arvanitidou	sema-icm@otenet.gr	ICM	yes, in journal	
no	No	Haiti	Cent. Amer	L			ICM		
yes	Yes	Hong Kong	Asia	H	Alice Sham	shamsv@ha.org.hk; midwives@netvigator.com	ICM	yes, at conferences, workshops and on website	meetings of our global region
yes	Yes	Indonesia	Asia	L	Harni Koesro	ppibi@ebn.net.id	ICM	to member list, MOH, public and private hospitals and clinics, through meetings and journal	presentations at meetings of global region, national and district levels

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PPH Survey	Are aware	Country	Region	*	Contact Person	Email	Affiliation	Disseminated to	Other activities conducted
no	Yes	Iran	Middle East				ICM	yes, throught educational programmes	
no	Yes	Ireland	Europe	H			ICM	yes, thorugh meetings	
no	yes	Japan	Asia	H			ICM	yes, through meetings and journal	
yes	Yes	Lebanon	Middle East	M	Sabine Abou malham	sabine.amalham@usj.lb; esf@usj.edu.lb; ndoughane@usj.edu.lb	ICM		
yes	Yes	Luxembourg	Europe		Schreiner-Kolbusch	bekagu@pt.lu; alsf@pt.lu	ICM	to our member list	presentation at national meetings
yes	Yes	Malawi	Africa	L	Lennie Adaeine Kamwendo	lennieakamwendo@yahoo.co.uk; kcnbt@malawi.net	ICM	yes, to gov and health institutions	other
no	yes	Mali	Africa	L			ICM	yes,	
no	yes	Malta	Europe				ICM	yes, through journal, education programmes, and to gov and health institutions	
yes	incomplete	Morocco	Middle East	M	Touria Harrizi	touria.sf@caramail.com	ICM		
Incomplete	Yes	Netherlands (the)	Europe	H	Marian Van Huis	amvanhuis@knov.nl; info@knov.nl	ICM		
no	yes	New Zealand	Asia	H			ICM	yes,	
yes	Yes	Norway	Europe	H	Marit Heiberg	marit@jordmorforeningen.no; amt@jordmorforeningen.no	ICM	to our member list	other
no	yes	Paraguay	South Amer	M			ICM	yes, through journal, conferences and progams, workshops	
yes	Yes	Peru	South Amer	M	Hilda Baca Neglia	hbaca@usmpxedu.pe	ICM		
yes	Yes	Philippines	Asia	M	Patricia M Gomez	imapinc@mozcom.com; amt@jordmorforeningen.no	ICM	to our member list	presentations at national meetings
no	no	Romania	Europe	M			ICM		
Incomplete	Yes	Senegal	Africa	L		marieme2001@yahoo.fr	ICM		
Incomplete	Yes	South Africa	Africa	M		NyathikaziN@dhw.norprov.gov.za	ICM		
yes	Yes	Spain	Europe	H	Dolors Costa	fame@federacion-matronas.org	ICM		
no	no	Suriname	South Amer				ICM		
yes	Yes	Sweden	Europe	H	Anna Nordfjell	anna.nordfjell@barnmorskeforbundet.se; kansli@barnmorskeforbundet.a.se	ICM	no, not relevant to context	
yes	Yes	Switzerland	Europe	H	Penelope V. Held	hrpheld@swissonline.ch; info@hebamme.ch	ICM	yes	
yes	Yes	Taiwan	Asia	M	Chan Shiu-Feng	ellenlaikino@yahoo.com.tw	ICM		at national meetomgs
no	Yes	Tanzania	Africa	L			ICM	yes, journal and conferences	
yes	Yes	Trinidad & Tobago	South Amer	M	Gloria Copeland, Debbie Lew.	ttam95@hotmail.com	ICM	yes, to member list and through meetings	presentations at national and district meetings
yes	Yes	Uganda	Africa	L	Dr. P. J. Ibembe	pjimbembe@yahoo.com; upma@africaonline.com.ug	ICM	yes, through meetings and journal	
yes	Yes	United Kingdom	Europe	H	Andrya Prescott	midwife@independentmidwife.com; andrea@dombrowe.gxn.co.uk	ICM	yes, through meetings and journal	
yes	Yes	USA	North Amer	H	Deanne Willson	dwilliams@acnm.org; info@acnm.org	ICM	yes, to member list and in journal	presentations at national meetings and other
no	Yes	Zimbabwe	Africa	L			ICM	yes, through meetings	

POPPHI: Tracking the distribution and awareness of the Joint Satement

PPH Survey	Are aware	Country	Region	*	Contact Person	Email	Affiliation	Disseminated to	Other activities conducted
yes	Yes	Japan	Asia	H	Shigeke Horiuchi	shigeko-horiuchi@slcn.ac.jp; sanba1@midwife.or.jp	ICM		
yes	Yes	Japan	Asia	H	Yae Yoshino	ye.yoshino@nurse.or.jp; intl@nurse.or.jp	other		
yes	Yes	Nepal	Asia	L	Meena Sharma	msharma@savechildren.org.np	other		
yes	incomplete	Portugal	Europe	H	Vizor Varela & Maria Alexaner	apeo.portugal@netcabo.pt	other		
yes	Yes	Tonga	Asia			anataukapa@hotmail.com	other		
		Kenyan Nurses Association							
	* Income level of countries noted as per data from the World Bank								

POPPHI: Tracking the distribution and awareness of the Joint Satement

	Joint Statement		Toolkit	Toolkit	PPT Presentations		Small grants			
Country	**Have received/are av**	**Have requested**	**Have received**	**Have requested**	**Have received**	**Have requested**	**Applied**	**Received**	**Integrated in curriculum**	**Experts identified**
Argentina		yes	yes	yes		yes				
Bangledesh				yes		yes				
Benin						yes		Yes with the Association of Midwives of Benin		
Bolivia			yes					Yes with National Scientific Society of Obstetric Nurses		
Brazil			yes	yes		yes				
Bulgaria		yes				yes				
Burkina-Faso		yes		yes		yes				
Cameroun				yes		yes				
Canada						yes				
Centrafrique										
Chile		yes	yes	yes		yes				
Colombia		yes	yes	yes		yes				
Costa Rica		yes	yes							
Cote-d'Ivoire										
Cuba			yes			yes				
Denmark		yes			yes	yes				
Dominican Republic			yes	yes		yes			yes	
Ecuador		yes	yes	yes						
El Salvador		yes	yes	yes		yes			yes	
Ethiopia				yes	yes	yes		Yes with the Ethiopian Burse Midwives Association		

POPPHI: Tracking the distribution and awareness of the Joint Satement

Country	Have received/are av	Have requested	Have received	Have requested	Have received	Have requested	Applied	Received	Integrated in curriculum	Experts identified
Finland		yes				yes				
Gabon										
Georgia				yes		yes				
Greece		yes		yes		yes				
Guatemala			yes	yes		yes				
Guinée										
Haiti		yes	yes	yes		yes				
Honduras			yes	yes		yes				
Hong Kong		yes								
Iceland						yes				
Iraq		yes		yes		yes				
Ireland										
Japan		yes				yes				
Jordan										
Kenya					yes					
Lebabanon										
Macao SAR		yes				yes				
Macedonia (Republic of)										
Malawi					yes			Yes with Association of Malawian Midwives (AMAMI)		
Mali										
Mauritanie										
Mexico		yes	yes	yes		yes				
Netherlands (The)				yes	yes					
Nicaragua		yes	yes	yes		yes				

POPPHI: Tracking the distribution and awareness of the Joint Satement

Country	Have received/are av	Have requested	Have received	Have requested	Have received	Have requested	Applied	Received	Integrated in curriculum	Experts identified
Niger										
Nigeria		yes		yes	yes	yes				
Norway		yes								
Pakistan										
Panama		yes	yes	yes		yes				
Paraguay			yes	yes		yes			Yes	
Peru			yes	yes		yes		Yes - with Peruvian Midwifery Association (COP)		
Poland		yes		yes		yes				
Qatar										
Rep. Dem. Du Congo										
Rep. Pop du Congo										
Saudi Arabia										
Senegal		yes		yes		yes				
South Africa					yes					
Sudan					yes					
Sweden		yes				yes				
Switzerland		yes		yes		yes				
Taiwan		yes		yes		yes				
Tanzania		yes		yes	yes	yes		Yes - with two partner associations		
Togo										

POPPHI: Tracking the distribution and awareness of the Joint Satement

Country	Have received/are av	Have requested	Have received	Have requested	Have received	Have requested	Applied	Received	Integrated in curriculum	Experts identified
Uganda	yes		yes		yes					
UK					yes					
Ukraine		yes		yes		yes				
Uruguay		yes	yes	yes		yes				
Venezuela			yes							
Zimbabwe					yes					
Afhanistan	yes			yes		yes				
Austria	yes									
Benin	yes					yes				
Bosnia and Herzegowina	no									
Burkina-Faso		yes		yes		yes				
Cameroun	yes		yes		yes					
Canada	yes									
Chile	yes	yes		yes		yes				
Croatia		yes				yes				
Cyprus										
Czech Republic						yes				
Denmark										
Ethiopia, Africa				yes		yes				
Equador										
Germany										
Ghana	yes		yes		yes					
Greece	yes									
Haiti	no									
Hong Kong	yes									
Indonesia	yes			yes		yes				

POPPHI: Tracking the distribution and awareness of the Joint Satement

Country	Have received/are av	Have requested	Have received	Have requested	Have received	Have requested	Applied	Received	Integrated in curriculum	Experts identified
Iran	yes									
Ireland	yes									
Japan	yes									
Lebanon		yes		yes		yes				
Luxembourg	yes									
Malawi				yes		yes				
Mali										
Malta										
Morocco										
Netherlands (the)		yes								
New Zealand	yes									
Norway	yes			yes						
Paraguay	yes									
Peru										
Philippines				yes		yes				
Romania	no									
Senegal										
South Africa										
Spain										
Suriname	no									
Sweden	yes									
Switzerland	yes									
Taiwan		yes				yes				
Tanzania	yes		yes		yes					
Trinidad & Tobago	yes			yes		yes				
Uganda	yes		yes		yes					
United Kingdom	yes	yes								
USA										
Zimbabwe	yes									

POPPHI: Tracking the distribution and awareness of the Joint Satement

Country	Have received/are av	Have requested	Have received	Have requested	Have received	Have requested	Applied	Received	Integrated in curriculum	Experts identified
Japan										
Japan										
Nepal		yes		yes		yes				
Portugal										
Tonga		yes		yes		yes				
Kenyan Nurses Association	yes				yes					
vel of countries noted as per										

Appendix F: Practical Guidance to the Field on use, Management and Storage of Oxytocics

DRAFT Synopsis

Practical guidance to the field on use, management and storage of oxytocics
March 21, 2006

Overall message:

Active management of the third stage of labor (AMTSL) should be practiced by all skilled birth attendants and oxytocin, the preferred and first line drug, should be available for their use.

From WHO, UNFPA, UNICEF & World Bank, the IMPAC series – Integrated Management of Pregnancy and Childbirth: *Managing Complications in Pregnancy and Childbirth, page C 73-74*

ACTIVE MANAGEMENT OF THE THIRD STAGE
Active management of the third stage (active delivery of the placenta) helps prevent postpartum haemorrhage. Active management of the third stage of labour includes:

- Immediate oxytocin;
- Controlled cord traction; and
- Uterine massage.

OXYTOCIN

- Within 1 minute of delivery of the baby, palpate the abdomen to rule out the presence of an additional baby (s) and give oxytocin 10 units I'm.
- Oxytocin is preferred because it is effective 2 to 3 minutes after injection, has minimal side effects and can be used in all women….

Important points:

A. The clinical and pharmacological superiority of oxytocin makes it the preferred and first line drug for prevention of PPH and treatment.

B. Oxytocin's better stability and lower cost supports the clinical recommendation of oxytocin as the first line drug for prevention and treatment of PPH.

C. There is very little variability between the manufacturers of oxytocin so there is less risk of a bad product.

To facilitate the use of oxytocin:

1. Remove the temperature recommendation from oxytocin labeling and allow the manufacturers to label it according to their stability studies.

2. Give explicit advice that oxytocin should be stored according to the manufacturer's specifications.

3. Messages:
    a. The preferred storage is refrigeration but oxytocin can be stored at room temperature for up to 3 months*.
        *depends on the manufacturers recommendation
    b. Oxytocin is not affected by light or freezing

4. Recognize that increased use of oxytocin (for every birth versus for only for treatment of PPH) will lead to higher turnover of drug stock which will:
    a. Potentially decrease the time oxytocin is in delivery rooms and out of the refrigeration
    b. Encourage the manufacturers to maximize heat stability

5. Allow for overfilling of ampoules of oxytocin that will extend the shelf life of an effective, potent drug.

6. WHO has identified a "heat stable" oxytocin as a "missing medication". Share this information widely to encourage research to maximize the temperature specifications

7. The WHO prequalification process could encourage a more heat stable oxytocin by requiring that oxytocin is stable up to at least 25°C.

8. Recognize that ergometrine has been the drug of choice and the only uterotonic available to many midwives for many years. An active effort is needed to persuade midwives, physicians (including medical school leaders), pharmacists, MOH, national pharmaceutical stores to use oxytocin as the first line drug and to make it available. Ergometrine should only be used for treatment when the oxytocin failed to prevent hemorrhage.

9. Inventory and storage systems for oxytocin:
    a. Find creative and innovative ways to maximize the ability of midwives, doctors and nurses to keep oxytocin available in the delivery room at all times—while keeping the remaining supply refrigerated or cool.

    b. Collaboration with pharmacists or those with refrigeration capabilities in the facility (or other local agent) is necessary as well as those responsible for the supply distribution system at the MOH.

Related points

- Injection safety guidance (Every oxytocin injection must be administered with a new sterile injection device) should be included in this effort. Making oxytocin in Uniject available to procuring agents (IDA, UNFPA, UNICEF and other manufacturers) will support this effort.
- Messages must be created and provided to communities about the dangers of abuse of oxytocin (or other uterotonics).

- Ergometrine should remain on the essential drug list as a second line drug for treatment of PPH.
- Misoprostol is a promising drug, with new research results available soon, that may allow AMTSL or other PPH prevention interventions to move further into communities and reach more childbearing women.

What organizations can do to facilitate the use of oxytocin for AMTSL

Organization	Activity	Date to be completed
USP	Make changes in the monograph: • to remove temperature requirements • to include the widest specifications possible • allow for overfilling (??) • share information with manufacturers	
WHO–Essential Drug dept	1. Prequalification process: • set requirements for maximum stability (25 C) • allow for overfilling in ampoule to extend shelf life 2. Encourage, or actively pursue, efforts to find a more heat stable oxytocin 3. Give manufacturers guidance on what the field wants and needs 4. Ensure that Briefing Papers on oxytocin, ergometrine and misoprostol are consistent with work and messages identified during Mr. 21 meeting in DC	
WHO–Making Pregnancy Safer department	1. Give prominence and highlight importance of AMTSL 2. Give guidance to field/country/regional offices to promote AMTSL 3. Hold technical consultation to address issues and identify ways to strengthen the uptake of AMTSL in the field 4. Provide guidance to the field to promote the use of oxytocin by midwives	
FIGO & ICM	1. Incorporate information and message from this meeting into current work and guidance 2. Actively pursue work with national associations to remove obstacles and ensure regulations allow midwives to use oxytocin for prevention and initial treatment of PPH	
IDA	1. Share information sheets with the group (Mr. 21 meeting) provided to national drug procurement groups, particularly those written for the field 2. Provide data and guidance to group on stability studies and storage issues, as available	
USAID	1. Continue to support projects and linking/cooperation between projects that work on AMTSL, PPH prevention and treatment and drug logistics and management 2. Provide support and possible funding for new initiatives that support the recommendations of this meeting	
Manufacturers	1. Ensure that labeling of oxytocin gives the widest specifications on temperature to allow broadest use in the field.	

What organizations can do to facilitate the use of oxytocin for AMTSL		
Organization	**Activity**	**Date to be completed**
	2. Continue dialogue with USP and group to share data and current specifications on oxytocin	
Projects: RPM+, Deliver, ACCESS, POPPHI	1. Continue collaboration and ensure that messages and work in the field are complimentary and work toward the same goal 2. Actively include messages and information from the Mr. 21 meeting in project work. 3. POPPHI will ensure follow-up of meeting and work with other agencies to ensure that suggested activities/recommendations are followed (e.g., fact sheet development for different target groups)	

Appendix G: Small Grant Baseline Survey Information

Nepal: Respondents who currently provide these practices for every birth during the third stage of labor:

AMTSL Component	Midwives	ob/gyn	Total
Administration of uterotonic drug within 1 minute of birth	66	5	71
Apply controlled cord traction and counter traction to the uterus to deliver the placenta	65	5	70
Massage the fundus of the uterus through the abdomen after delivery of the placenta	64	4	68
Immediate clamping of the cord	66	3	69

Benin

Summary information on AMTSL in births in its health facility:

Details											
Name of District	Loto*	Littoral	Littoral	Cujo Cajamar	Littoral	Cotonou I et IV	Littoral	Commune De Ro*	Bohican	Aboney	Littoral
Name of clinic	Clinique d'Accou*	Clinique les Graces	Clinique **	Cujo	CuGO/ CHHN	HONEL	Clinique U*	CSC de Hauime	Clinique Grace*	CHD Zou-Colline	Mc Ahauvian*
Number of births at clinic, hospital or workplace in the past 3 months	52	20	631	413	413	735	413	130	84	474	218
Number of births at clinic, hospital or workplace that received AMTSL in the past 3 months	44	20	377	377	377	636	377	130	84	474	206

Did not receive national level information from this survey or the summarized information; just received individual member forms.

Uganda

Respondents who currently provide these practices for every birth during the third stage of labor:

AMTSL Component	Midwives	ob/gyn	Total
Administration of uterotonic drug within 1 minute of birth	1	2	3
Apply controlled cord traction and counter traction to the uterus to deliver the placenta	3	2	5
Massage the fundus of the uterus through the abdomen after delivery of the placenta	7	2	9
Immediate clamping of the cord	4	2	6

We received baseline information from 8 midwives and 0 ob/gyns for the following:
Summary information on AMTSL in births in its health facility:

Details								
Name of District	Kiboga	Kiboga	Kiboga	Kiboga	Kiboga	Kibaale	Kibaate	Kibaale
Name of clinic	Kiboga Hospital	Lwemata H/C	Botema H/C III	St Paul Dominican clinic	Ndibula Domicilary Maternity	Akwetaire Domicilary Centre	Mabaale HC III	Abesiga-Mukama domiciliary
Number of births at clinic, hospital or workplace in the past 3 months	445, 366	29	9	8	7	7	47	4
Number of births at clinic, hospital or workplace that received AMTSL in the past 3 months	374, 70%	0	9	8	0	0	47	0

Received national level information but did not receive POPPHI summary tables filled out.

Dominican Republic

There are 9 districts in total in the country.
They targeted 5 facilities with its small grant activities.
They targeted 55 midwives, and 55 ob/gyns with its small grant activities.

We received summary baseline information from 4 midwives and 13 ob/gyns.

Respondents who currently provide these practices for every birth during the third stage of labor:

AMTSL Component	Midwives	ob/gyn	Total
Administration of uterotonic drug within 1 minute of birth	4	11	15
Apply controlled cord traction and counter traction to the uterus to deliver the placenta	2	7	9
Massage the fundus of the uterus through the abdomen after delivery of the placenta	3	13	16
Immediate clamping of the cord	4	7	11

We did not receive filled out summary information for our Indicator 1, and did not provide individual member survey details so do not have district level information, so cannot compile data for Indicator 1.

We received summary baseline information from 5 matrons and 18 ob/gyns (some additional duplicates for hospital where the numbers are the same not included here)

Respondents who currently provide these practices for every birth during the third stage of labor:

Details										
Name of District	District 1	District 1	HDB Povo	District 1	District 1	District 1	Sucre 1	District 1	Potosi	Potosi
Name of clinic	Hospital Salma*	Hospital Gineo*	Hospital Daniel	Hospital Jamie*	Naja*	Hop Anton*	H.60	Hosp par Pedro*	Hosp Ob*	Hosp Daniel*
Number of births at clinic, hospital or workplace in the past 3 months	200	900	390	150	25 to 30	90	400	320	350	450
Number of births at clinic, hospital or workplace that received AMTSL	0	720	Unknown	0	0	30	100	60%	175	Unknown

Details										
in the past 3 months										

Details										
Name of District	Potosi	Sucre	Sucre	Lanjatambo	Sucre-District N-J	District 1	District 1	Caje*	Potari-Caja	District 1
Name of clinic	CNS - Potosi	Potali	HFM	Hospital san Pedro*	Hos Jamie*	HJM	H Petro*	Hosp CNS	Hosp#5 CNS	Hosp Hudos*
Number of births at clinic, hospital or workplace in the past 3 months	400-450	50	200	320	200, 300	300	25-30	420	420 +/-	50
Number of births at clinic, hospital or workplace that received AMTSL in the past 3 months	0	20	50	Unknown	50, U	10	10	0	0	Unknown

Details			
Name of District	Sucre–I	Potosi	District 1
Name of clinic	Hosp Potonos	Hoson*	Hosp Guien
Number of births at clinic, hospital or workplace in the past 3 months	120	300+/-	720
Number of births at clinic, hospital or workplace that received AMTSL in the past 3 months	0	Unknown	Unknown

Appendix H: Training Actuals for 2006

#	Country	Small Grants Country	2006 Training Overview, dates, participants (end of July 2006)	Actual Number trained 2006 (end of July 2006)	Target Number trained 2006 (end of Sept 2006)
7.	Malawi	Train or update 29 SM trainers; 5 key persons in health training institute/ 100 clinical officers = 134	Program 27th July 2006 Trained Nurse Midwife Tutor (1) , Midwifery Lecturer (2) , RN/M Assistant Lecturer, RN/M - Deputy Director (3), Clinical Services (RHU), RN/Midwife - Tutor, Clinical Officer – Tutor (4), RN/M -Assistant Lecturer, RN/M - Safe Motherhood Coordinator, RN/M - Chief Nursing Officer Q.A. (5)	37 total 5 key persons in health training institute 1 SM trainer	134
8.	Ghana		The joint SOGOG and GRMA program planning committee organized its first of two dissemination workshops on AMTSL. The workshops were comprised of lectures and discussions aimed to ensure the application of AMTSL throughout the ten regions of Ghana. Attendees were given information on AMTSL and evidence-based research supporting its utility; presented with data on regional statistics of postpartum maternal hemorrhage and pre-workshop management of the third stage of labor; presented with and then practiced the skills in AMTSL; and participated in a discussion of the role of health professionals in the dissemination of AMTSL. As a result of this workshop, the	100	100

#	Country	Small Grants Country	2006 Training Overview, dates, participants (end of July 2006)	Actual Number trained 2006 (end of July 2006)	Target Number trained 2006 (end of Sept 2006)
			attendees were encouraged to develop and implement further dissemination of the important benefits and skills involved in AMTSL within their local regions.		
9.	Tanzania	15 participants per municipality x 5 municipalities = 75	[Participants for these workshop were drawn from city hospitals namely Temeke, Mwanyamala, Ilala and some from selected health centers both private and public which has high numbers of deliveries] 34 service providers were updated on the current practice of AMTSL on June 21–22 July 12–13, 2006 at Muhimbili National Hospital	34	75
2	Nepal	4 regions x 20 participant per region = 80	Two days of trainer's training workshop for preparation of trainers on AMTSL was organized at Kathmandu on March 16–17 at training hall of Kathmandu Medical College. There were 20 participants altogether, of which 10 gynecologists and 10 nurses representing NESOG and NAN respectively. This training was facilitated by the trainers who attended the Asia region workshop held in Delhi. Two days Training on "Active Management of Third Stage of Labor" was organized and	82	80

#	Country	Small Grants Country	2006 Training Overview, dates, participants (end of July 2006)	Actual Number trained 2006 (end of July 2006)	Target Number trained 2006 (end of Sept 2006)
			conducted March 26-27, 2006 at Pokhara. Altogether 23 participants attended the training. Two days training on AMTSL was conducted at Bheri Zonal Hospital on March 26–27, 2006. A total of 21 participants participated with full energy and enthusiasm. Eastern region Inaruwa, Sunsari, March 26–27, 2006. A total of 18 participants. Two days training on AMTSL in Dhulikhel Kavre, was organized and conducted in Dhulikhel community Hospital on March 26-27, 2006. There were 20 participants in number comprising from the hospital, various PHC, HP and SHP as well as DHO of Kavre District.		

Figure 3 Detailed Training Information